

Case Number:	CM14-0046555		
Date Assigned:	07/02/2014	Date of Injury:	03/26/1999
Decision Date:	08/22/2014	UR Denial Date:	04/09/2014
Priority:	Standard	Application Received:	04/14/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 64-year-old male who has submitted a claim for Cervical Spine Herniated Nucleus Pulposus, Lumbar Spine Herniated Nucleus Pulposus, and Rule Out Hip Pathology, associated with an industrial injury date of March 26, 1999. Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of neck, low back, and hip pain. On physical examination, there was tenderness of the cervical spine and Spurling's sign was positive bilaterally. EMG/NCV of the upper extremities dated December 26, 2014 revealed evidence of a mild bilateral carpal tunnel syndrome affecting sensory components; and no electrodiagnostic evidence of ulnar nerve entrapment, brachial plexopathy, or cervical radiculopathy. MRI of the cervical spine dated May 7, 2014 revealed multilevel degenerative changes, which is most pronounced from C4 through C6 where there is moderate to appreciable spinal stenosis as well as neural foraminal narrowing; and no evidence for acute appearing cord compression. MRI of the lumbar spine dated May 7, 2014 revealed multilevel mild disk disease; mild loss of disk hydration from L3 through L5; a 1-mm disk bulge at L3-4 with no foraminal or spinal stenosis; a 1-2 mm annular disk bulge at L4-5 with no foraminal or spinal stenosis; and a 2-mm annular disk bulge at L5-S1 with no appreciable foraminal or spinal stenosis. Treatment to date has included medications. Utilization review from April 9, 2014 denied the request for MRI CS and MRI LS because there was no objective finding of radiculopathy and there were no red flags or surgical plans noted; and Standing (B) hip/pelvis 2 view because there was no recent trauma and no hip exam was documented.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

MRI CS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178, 303-304 and revised 52-59. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (http://www.odg-twc.com/odgtwc/low_back.htm#Radiography).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180.

Decision rationale: According to pages 179-180 of the ACOEM Practice Guidelines referenced by CA MTUS, imaging studies are supported for red flag conditions; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program; and clarification of the anatomy prior to an invasive procedure. In this case, although tenderness of the cervical spine and Spurling's sign was noted on physical exam, electrodiagnostic evidence did not reveal evidence of cervical radiculopathy. Furthermore, the records did not show presence of red flag conditions and there was no discussion regarding failure to progress in a strengthening program. There was also no discussion regarding a planned invasive procedure. There is no clear indication for MRI of the cervical spine at this time. Therefore, the request for MRI CS is not medically necessary.

MRI LS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178, 303-304 and revise pages 52-59. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (http://www.odg-twc.com/odgtwc/low_back.htm#Radiography).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

Decision rationale: According to pages 303-304 of the ACOEM Practice Guidelines referenced by CA MTUS, imaging of the lumbar spine is supported in patients with unequivocal objective findings that identify specific nerve compromise on the neurologic examination, and who do not respond to treatment, and who are in consideration for surgery. In this case, although the patient complained of low back pain, there was no recent physical examination findings pertaining to the lumbar spine that identified nerve compromise. In addition, there was no discussion regarding failure of current management and there was also no discussion regarding surgical plans. There is no clear indication for MRI of the lumbar spine at this time. Therefore, the request for MRI LS is not medically necessary.

Standing (B) hip/pelvis 2 view: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pelvis and hip.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hips and Pelvis, X-Ray.

Decision rationale: CA MTUS does not specifically address x-ray of the hips and pelvis. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines (ODG) was used instead. ODG states that x-ray is recommended. Plain radiographs of the pelvis should routinely be obtained in patients sustaining a severe injury. X-rays are also valuable for identifying patients with a high risk of the development of hip osteoarthritis. In this case, the records did not show recent severe injury to the hips and pelvis. Furthermore, the patient was not identified as being high risk for hip osteoarthritis. There is no clear indication for hip/pelvis radiograph at this time. Therefore, the request for Standing (B) Hip/Pelvis 2 view is not medically necessary.