

Case Number:	CM14-0179032		
Date Assigned:	11/03/2014	Date of Injury:	10/13/2001
Decision Date:	01/27/2015	UR Denial Date:	10/27/2014
Priority:	Standard	Application Received:	10/28/2014

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 Internal Medicine and is licensed to practice in New York. 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 58 year old female bakery clerk with a date of injury of 10/13/2001. She was pulling a large metal cabinet that hit a hole and fell on top of her. She had low back pain. On 12/08/2005 she was P&S for bilateral lumbar radiculopathy. On 12/19/2006 she had a L3-L4 discectomy. On 05/06/2008 she had a right shoulder MRI that revealed a lipoma. The shoulder joint was normal. On 08/04/2009 she had a lumbar MRI that revealed a L2-L3 and L3-L4 annular tear. She had There was L4-L5 neuroforaminal narrowing. On 05/29/2012 a repeat right shoulder MRI revealed subacromial bursa effusion. There was acromioclavicular arthropathy. A MRI of the cervical spine that day revealed a prior C5-C6 and C6-C7 fusion. The C6 and C7 existing nerves were normal with no stenosis. There was disc dissication of C2-C3, C3-C4 and C4-C5. On 06/18/2012 a lumbar MRI revealed a previous L4-L5 and L5-S1 fusion with decompressive laminectomy. There was bilateral L3 neural foraminal stenosis. L4 and L5 exiting nerves were unremarkable. She had transforaminal epidural steroid injections at L4-L5 on 06/08/2010, 11/15/2013, 12/06/2013 and 03/14/2014. On 10/29/2013 she had low back pain radiating to the lower extremities mostly at left L4 and L5 dermatomes. On 11/26/2013 there was improvement but now the pain was worse in the right lower extremity. On 05/19/2014 she again had mostly low back pain radiating to the left L4, L4 dermatomes. On 08/26/2014 there was again lumbar radiculopathy to both lower extremities, left worse than right. There was numbness in both lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT scan lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.odg-twc.com/index.html:odgtwc/low_back.htm

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287 - 316.

Decision rationale: The patient already had multiple lumbar imaging studies. ACOEM Chapter 12 Low Back Complaints notes that there must objective documentation of red flag signs, new findings or the patient is a surgical candidate to another imaging study. There is no documentation of any new findings for this patient with a chronic lumbar radiculopathy and there was no documentation that another lumbar surgery is being contemplated. Therefore, this request is not medically necessary.

Cervical spine MRI without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177 and 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 165 - 188.

Decision rationale: ACOEM Chapter 8 notes that in the absence of red flag signs or new findings (symptoms or exam) there is no indication for another cervical spine imaging study. There is no documentation that she is a candidate for another cervical spine surgery. She is stable and there is insufficient documentation to substantiate the medical necessity of another cervical MRI. Therefore this request is not medically necessary.