

Case Number:	CM14-0188942		
Date Assigned:	11/19/2014	Date of Injury:	02/05/2003
Decision Date:	01/07/2015	UR Denial Date:	10/13/2014
Priority:	Standard	Application Received:	11/12/2014

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 Family 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 injured worker is a 54 year old male with a date of injury of February 5, 2003. The results of the injury included increased cervical, low back pain, and bilateral leg pain. Diagnosis include status post anterior-posterior cervical fusion, C3-6, 2/17/05, status post right shoulder arthroscopy, bilateral hernia, status post anterior-posterior spinal fusion L4-S1, bilateral knee pain, significant, with magnetic resonance imaging positive for medial femoral condyle osteonecrosis and joint effusion, left knee, moderate bilateral carpal tunnel syndrome, and status post lumbar hardware removal and exploration of fusion, August, 2010. Per the Utilization review magnetic resonance imaging dated September 27, 2011 revealed posterior disc buldges of 3 to 4 mm at L2-3 and L3-4 without central canal narrowing, mild bilateral L3 4 facet hypertrophy, status post L4-5 interbody fusion, and obscuration of the right neural foramen at L5-S1 by para magnetic artifact. Examination dated September 25, 2014 showed tenderness in the lumbar, paraspinous regions. Range of motion was decreased. Muscle spasms were present. Straight leg raise was positive to the left and right leg. Sensation was decreased. Work status remains at total temporary disability. Treatment included opiate therapy, toradol, tens unit, psychological evaluation, antidepressants, muscle relaxers, cognitive behavioral training, and localized trigger point injections with good result. Utilization review form dated October 13, 2014 noncertified a Magnetic resonance imaging scan of the lumbar spine with and without contrast due to lack of compliance with Official Disability Guidelines recommendations.

IMR ISSUES, DECISIONS AND RATIONALES

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

One MRI of the lumbar spine with and without contract: 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), Low Back, MRIs

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: According to the ACOEM guidelines, an MRI of the lumbar spine is recommended for red flag symptoms such as cauda equine, tumor, infection, or uncertain neurological diagnoses not determined or equivocal on physical exam. In this case, the claimant had an MRI of the lumbar spine a few months previously. There were no new injuries, plan for surgery or clinical findings that necessitate another MRI. The request for an MRI of the lumbar spine is not medically necessary.