

Case Number:	CM15-0006067		
Date Assigned:	01/29/2015	Date of Injury:	09/23/2010
Decision Date:	03/25/2015	UR Denial Date:	12/12/2014
Priority:	Standard	Application Received:	01/12/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 (IW) is a 51 year old male, who sustained an industrial injury on September 23, 2010. He has reported constant neck pain radiating to the arms and hand with numbness and tingling noted, low back pain and pain radiating to the lower extremities with associated weakness, numbness and tingling and was diagnosed with prior anterior/posterior cervical spine fusion, lumbar 3-sacral 1 disc herniation and discogenic changes. Treatment to date has included radiographic imaging, diagnostic studies, surgical intervention, physical therapy, psychological evaluation, acupuncture, pain medications and other treatment modalities. Currently, the IW complains of constant neck pain, low back pain and pain radiating to the lower extremities with associated weakness, numbness and tingling. The injured worker reported a work related injury in 2010, resulting in constant pain as described above. He underwent multiple failed conservative therapies and required pain medications. On June 29, 2014, the pain continued. Wrist splints, anti-inflammatories, stomach medication, a TENS unit and a home exercise plan were ordered. On September 15, 2014, the pain was noted as constant and rated at a 7-8 on a 1-10 scale. A right carpal tunnel injection was requested. On December 10, 2014, Utilization Review non-certified a request for a magnetic resonance image of the brain and lumbar spine, aqua therapy, psychiatrist referral and carpal tunnel re-evaluation, noting the MTUS, ACOEM Guidelines, (or ODG) was cited. On December 8, 2014, the injured worker submitted an application for IMR for review of the above request.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI lumbar: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low back chapter, MRIs (magnetic resonance imaging)

Decision rationale: The patient presents with constant neck and low back pain rated 7-8/10 radiating to the lower extremities with associated weakness, numbness and tingling. The request is for MRI LUMBAR. The RFA is not provided. Medical records provided were hand-written, illegible, and difficult to interpret. Per the AME report dated 10/07/14, patient was diagnosed with major depressive affective disorder, single episode, unspecified and pain disorder. Patient is temporarily totally disabled. ODG guidelines, Low back chapter, MRIs (magnetic resonance imaging) (L-spine) state that "for uncomplicated back pain MRIs are recommended for radiculopathy following at least one month of conservative treatment." ODG guidelines further state the following regarding MRI's, Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). In this case, treater does not provide a rationale for the repeat lumbar MRI. Per the imaging study report dated 08/15/13, the patient underwent a lumbar MRI which revealed straightening of the lumbar lordotic curvature with an element of myospasm, disc desiccation at L3-14 down to L5-S1 with loss of disc height at L5-S1, and L5-S1 diffuse disc herniation which causes stenosis of the spinal canal and of the bilateral neural foramen. On 06/26/14, the patient underwent another lumbar MRI which showed the L4-5 disc level dehiscence of the nucleus pulposus with a 3mm posterior disc bulge. In review of the clinical information, there are no evidence of new injuries, no defined clinical changes from the time of the prior studies to present, and no new locations of symptoms that would require additional investigation. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Therefore, the request IS NOT medically necessary.

MRI brain without contrast: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation head chapter, MRI

Decision rationale: The patient presents with constant neck and low back pain rated 7-8/10 radiating to the lower extremities with associated weakness, numbness and tingling. The request is for MRI BRAIN WITHOUT CONTRAST. The RFA is not provided. Medical records provided were hand-written, illegible, and difficult to interpret. Per the AME report dated 10/07/14, patient was diagnosed with Major depressive affective disorder, single episode,

unspecified and pain disorder. Patient is temporarily totally disabled. ODG Guidelines under its head chapter, MRI, states this is a well-established brain imaging study and it is indicated as follows: Explain neurological deficit not explained by CT, to evaluate prolonged interval of disturbed consciousness to determine evidence of acute changes superimposed on previous trauma or disease. MRI is more sensitive than CT for detecting traumatic cerebral injury. In this case, treater does not provide a rationale for the brain MRI. On 08/17/13, a cervical MRI was performed which showed disc desiccation at C2-C3 down to C6-C7 with associate loss of disc height and straightening of the normal cervical lordosis. On 09/05/14 a CT scan of cervical spine revealed anterior fusion with a metallic prosthesis in place. ODG supports MRI studies to explain neurological deficit not explained by CT and to evaluate prolonged interval of disturbed consciousness to determine evidence of acute changes superimposed on previous trauma or disease. In this case, review of the clinical information did not show any subjective complains of headaches, sleep disturbance, dizziness, and blurry vision, balance and memory problems or any neurological deficit on the CT scan. Therefore, the request IS NOT medically necessary.