

Case Number:	CM15-0133318		
Date Assigned:	07/21/2015	Date of Injury:	05/06/2015
Decision Date:	08/17/2015	UR Denial Date:	07/06/2015
Priority:	Standard	Application Received:	07/10/2015

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 34 year old female who sustained a work related injury May 6, 2015. Past history included neurological disease and migraine headaches. According to emergency department (ED) physician notes, dated May 7, 2015, the injured worker presented to the ED with complaints of headache, back pain, and nausea. She fell the previous day at work and hit her head on a shelf, without loss of consciousness. She arrived walking, with a steady gait. She complains of left side top of the head pain, with redness at the site of injury, no swelling, bruising, or other signs of trauma. She received intramuscular pain medication, sublingual Zofran ODT, and Norco. CT of the head revealed no acute intracranial abnormalities. CT of the spine, cervical revealed no acute bony abnormalities. Diagnoses are head injury not otherwise specified; contusion face, scalp, neck; headache. According to a physician's notes, dated June 19, 2015, the injured worker presented with complaints of lumbar and cervical pain. She is starting additional chiropractic treatment today after completing 8 visits. Heel toe ambulation is performed without difficulty, straight leg raise is negative and the back muscles display no weakness. There is tenderness to palpation of the cervical spine and decreased range of motion of the neck. Diagnoses are sprain, strain, cervical; sprain lumbosacral. At issue, is the request for authorization for an MRI of the cervical spine without contrast and an MRI of the lumbosacral spine without contrast.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI without contrast of the Lumbosacral Spine: Upheld

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

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

Decision rationale: Regarding the indications for imaging in case of back pain, MTUS guidelines stated: "Lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. However, it may be appropriate when the physician believes it would aid in patient management. Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures)." Furthermore, and according to MTUS guidelines, MRI is the test of choice for patients with prior back surgery, fracture or tumors that may require surgery. The patient does not have any clear evidence of lumbar radiculopathy or nerve root compromise. His recent lumbar X-ray performed on May 2015 was negative for acute lesion. There is no change of the clinical examination There is no clear evidence of significant change of the clinical examination of the patient compared to it examination when the last X ray of the lumbar spine was performed. There is no change in the patient signs or symptoms suggestive of new pathology. Therefore, the request for MRI without contrast of the Lumbosacral Spine is not medically necessary.

MRI without contrast of the Cervical Spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

Decision rationale: According to MTUS guidelines, MRI of the cervical spine is recommended in case of red flags suggesting cervical spine damage such as tumor, infection, cervical root damage and fracture. There is no documentation of any of these red flags in this case. The patient underwent a CT of the cervical spine which demonstrated no acute pathology. There is no documentation of change of the patient condition since that time. Therefore the request for MRI without contrast of the Cervical Spine is not medically necessary.