

Case Number:	CM15-0223196		
Date Assigned:	11/19/2015	Date of Injury:	10/07/2015
Decision Date:	12/31/2015	UR Denial Date:	11/12/2015
Priority:	Standard	Application Received:	11/13/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 22 year old male, who sustained an industrial-work injury on 10-7-15. A review of the medical records indicates that the injured worker is undergoing treatment for sprain of the shoulder, strain of the muscle-fascia-tendon and sprain of the ligaments of the neck. Treatment to date has included Non-steroidal anti-inflammatory drugs, Motrin, Dilaudid, Zofran, and Flexeril, diagnostics, activity modifications and other modalities. The x-rays of the thoracic spine, lumbar spine and pelvis dated 10-7-15 were all unremarkable. Medical records dated 11-5-15 indicate that the injured worker complains of pain in the neck, shoulders and lumbar spine. He complains of sharp pain in the legs but denies paresthesia or weakness. The physician indicates that there are no changes and he is not improved with Non-steroidal anti-inflammatory drugs and Flexeril. He is starting physical therapy this week. Per the treating physician report dated 11-5-15 the work status is modified on 11-5-15 with restrictions. The physical exam reveals decreased cervical range of motion, moderate tenderness of the trapezius borders. Lumbar tenderness to palpation L4-5 and spasm of the paraspinous muscle. The medical records do not reveal any red flags noted by the treating physician or neurological deficits with regards to the physical exam for the cervical spine and lumbar spine. The request for authorization date was 11- 5-15 and requested services included MRI lumbar spine and MRI cervical spine. The original Utilization review dated 11-12-15 non-certified the request for MRI lumbar spine and MRI cervical spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, MRIs (Magnetic resonance imaging).

Decision rationale: Per the ODG guidelines with regard to MRI of the lumbar spine: Recommended for indications below. MRI's are test of choice for patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy, not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). (Bigos, 1999) (Mullin, 2000) (ACR, 2000) (AAN, 1994) (Aetna, 2004) (Airaksinen, 2006) (Chou, 2007) Magnetic resonance imaging has also become the mainstay in the evaluation of myelopathy. An important limitation of magnetic resonance imaging in the diagnosis of myelopathy is its high sensitivity. Indications for imaging: Magnetic resonance imaging: Thoracic spine trauma: with neurological deficit; Lumbar spine trauma: trauma, neurological deficit; Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit); Uncomplicated low back pain, suspicion of cancer, infection, other "red flags;" Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit; Uncomplicated low back pain, prior lumbar surgery; Uncomplicated low back pain, cauda equina syndrome; Myelopathy (neurological deficit related to the spinal cord), traumatic; Myelopathy, painful; Myelopathy, sudden onset; Myelopathy, stepwise progressive; Myelopathy, slowly progressive; Myelopathy, infectious disease patient; Myelopathy, oncology patient; Repeat MRI: When there is significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). The documentation submitted for review does not contain positive physical examination findings regarding the lumbar spine or indication of subjective complaints of pain to the lumbar spine noted for review that would support the role of an MRI. There are no documented motor, sensory or functional deficits, or aforementioned indication. Without evidence of acute change in injured worker's clinical symptoms or positive physical examination findings, an MRI is not supported. The request is not medically necessary.

MRI cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Magnetic resonance imaging (MRI).

Decision rationale: Per the ODG guidelines with regard to MRI of the lumbar spine: Not recommended except for indications list below. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, and have no neurologic findings, do not need imaging. Patients who do not fall into this category should have a three-view cervical radiographic series followed by computed tomography (CT). In determining whether or not the patient has ligamentous instability, magnetic resonance imaging (MRI) is the procedure of choice, but MRI should be reserved for patients who have clear-cut neurologic findings and those suspected of ligamentous instability. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). (Anderson, 2000) (ACR, 2002) See also ACR Appropriateness Criteria. MRI imaging studies are valuable when physiologic evidence indicates tissue insult or nerve impairment or potentially serious conditions are suspected like tumor, infection, and fracture, or for clarification of anatomy prior to surgery. MRI is the test of choice for patients who have had prior back surgery. (Bigos, 1999) (Bey, 1998) (Volle, 2001) (Singh, 2001) (Colorado, 2001) For the evaluation of the patient with chronic neck pain, plain radiographs (3-view: anteroposterior, lateral, open mouth) should be the initial study performed. Patients with normal radiographs and neurologic signs or symptoms should undergo magnetic resonance imaging. If there is a contraindication to the magnetic resonance examination such as a cardiac pacemaker or severe claustrophobia, computed tomography myelography, preferably using spiral technology and multiplanar reconstruction is recommended. (Daffner, 2000) (Bono, 2007). Indications for imaging: MRI (magnetic resonance imaging); Chronic neck pain (after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present; Neck pain with radiculopathy if severe or progressive neurologic deficit; Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present; Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present; Chronic neck pain, radiographs show bone or disc margin destruction; Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal;" Known cervical spine trauma: equivocal or positive plain films with neurological deficit; Upper back/thoracic spine trauma with neurological deficit. The documentation submitted for review does not contain positive physical examination findings regarding the cervical spine or indication of subjective complaints of pain to the cervical spine noted for review that would support the role of an MRI. There are no documented motor, sensory or functional deficits, or aforementioned indication. Without evidence of acute change in injured worker's clinical symptoms or positive physical examination findings, an MRI is not supported. The request is not medically necessary.