

Case Number:	CM15-0031566		
Date Assigned:	02/24/2015	Date of Injury:	09/24/2002
Decision Date:	04/22/2015	UR Denial Date:	02/09/2015
Priority:	Standard	Application Received:	02/19/2015

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: Oregon, California
 Certification(s)/Specialty: Neurological Surgery

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 53-year-old male who reported an injury on 09/24/2002. The mechanism of injury was not provided. The documentation of 02/27/2014 revealed the injured worker had a recent fall where he tripped and fell over a mat and hit his head on a metal rack. The injured worker was noted to be complaining of severe cervical and lumbar spine pain and the neck pain was worse. The injured worker was noted to receive Norco which was not helping. The physical examination revealed, neurologically, the injured worker was stable on examination and had full strength of the bilateral upper extremities and strength was 5/5 in the deltoids, biceps, triceps, wrist extensors, flexors, and grip was full. Radiographs revealed a solid fusion at C4-6 without acute fracture and x-rays of the lumbar spine revealed a stable placement of hardware spanning L2-S1 and at the right sacroiliac joint. There were no acute fractures in these areas. The treatment plan included a Medrol Dosepak. The documentation of 01/15/2015 revealed the injured worker had a history of multiple falls due to right sided weakness. The documentation indicated there had been a request for an MRI; however, none had been done. The injured worker was noted to have an L1-2 grade 1 retrolisthesis stable in flexion and extension views. The physical examination revealed a nonfocal sensory examination of the left upper and lower extremity. The injured worker had strength testing on the right EHL and peroneal post-tibial and gastroc of 4/5. The injured worker had right side deficits on the deltoid, biceps, wrist extensor, and flexor of 4/5. The diagnoses included thoracic/lumbosacral neuritis unspecified, spinal stenosis lumbar with neurogenic claudication, brachial neuritis unspecified, and spinal stenosis cervical region. The treatment plan included an MRI of the cervical spine and lumbar spine due

to myelopathy and upper and lower extremity weakness on examination. The physician documented there was a need to rule out spinal cord compression and the injured worker should have a possible EMG in the neck and lumbar spine if the MRI was equivocal.

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 Lumbar: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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 Chapter, MRI.

Decision rationale: The patient was noted to require an updated MRI of the lumbar spine due to increased pain and motor deficits on examination. The Official Disability Guidelines indicate that repeat MRIs are recommended when there is a significant change in symptoms or objective findings upon physical examination. The clinical documentation submitted for review indicated the injured worker had a prior MRI. The documentation indicated the injured worker had recent falls. However, there was a lack of documentation of prior objective physical examinations to support the injured worker had a significant change in symptoms or findings. Given the above, the request for MRI without contrast of the lumbar is not medically necessary.