

Case Number:	CM14-0163486		
Date Assigned:	10/08/2014	Date of Injury:	04/28/2012
Decision Date:	11/07/2014	UR Denial Date:	09/12/2014
Priority:	Standard	Application Received:	10/06/2014

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 Internal 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 (IW) is a 63-year-old man who sustained an industrial injury on April 28, 2012. He was involved in a hit and run accident. The IW was found unconscious. He sustained a subarachnoid hemorrhage, acute subdural hematoma, combined fractures of the orbital floor, comminuted fractures of the right antrum and posterior lateral maxillary sinus wall, fractures of the pterygoid process, and left-sided rib fractures with hemothorax. He was admitted to the trauma center and he was induced into a coma for 10 days to allow the swelling in his brain to reduce. It was determined by the attending physicians that he has a concussion, neck injury, clot in the left lung, a fractures left clavicle, fractured rib cage, punctured left lung and fractured right eye socket and right cheekbone. After he came out of the coma, surgery was done to remove the blood clot from his left lung and to repair the left clavicle fracture. He also had surgery to repair the fractured eye socket and the right cheekbone. He was released after one month and transferred an acute rehabilitation center in May 2012 for physical and mental rehabilitation. He eventually transferred to a transitional living center residential program in June 2012. He completed this program in August 2012. Treatment included physical therapy, medications, and inpatient/outpatient cognitive therapy. MRI of the lumbar spine completed on July 30, 2013 with the following findings: L4-5 circumferential disc bulge, along with bilateral facet arthrosis and mild ligamentum flavum thickening, results in mild to moderate narrowing of the central spinal canal and crowding of the lateral recess. Despite this, there does not appear to be any contact of the existing L4 nerve roots. There is moderate to severe bilateral neural foraminal narrowing at this level. The maximum AP diameter of the central canal at this level is 8mm. L5-S1: Circumferential disc bulge, eccentric to the left, which along with moderate bilateral facet arthrosis, results ad mid narrowing on the central spinal canal and crowding of the left lateral recess. There may be contact with the existing L5 nerve roots. There is mild bilateral neural

forminal narrowing. Impression: Severe degenerative changes of the lumbar spine, with multi-level degenerative disc disease and spinal stenosis. The most severe is L3-4 where there is a maximum AP diameter of 7 mm due to combination of circumferential disc bulge, facet degenerative changes and ligamentum flavum thickening. An MRI of the cervical spine was complete on July 30, 2013. The impression revealed: Cervical spondylosis that is most severe at C5-6 where there is moderate to severe spinal stenosis with a maximum diameter of 7 mm. There is also severe bilateral neural foraminal narrowing at this level. There are similar findings at C6-7, but to a lesser degree. Pursuant to the June 5, 2014 examination, the IW reports lower back pain and bilateral radiating leg pain, right greater than left, rated 7/10 in intensity. He states that the IW would benefit from both epidural and facet injections, which he would like to perform at the same time. Examination reveals that lumbar spine range of motion is restricted by approximately 50%. Ankle strength is 5/5 in all directions right sensory L5 distribution deficit. According to the August 28, 2014 progress report, the IW reports some pain in the right shoulder that he believes is rotator cuff related. The IW has primary complaints of lower back and radiating leg pain. Of note, the lumbar spine MRI from July 30, 2013 is consistent with recent x-rays. He knows that there are significant radiating symptoms in the left leg. He recommends the use of narcotic analgesics and the need ultimately for lumbar spinal surgery. The IW is diagnosed with 1. Status-post cervical fusion improved. 2. Lumbar spinal stenosis. 3. Lumbar scoliosis. 4. Lumbar spondylolysis. 5. Left L5 sciatica and weakness. The treating physician notes that the IW has not had any opioid medications over the last several weeks, and has had a withdrawal, and is requesting medication today. Norco 10/325mg is to be taken every 2 to 4 hours is dispensed. The IW is temporarily totally disabled until November 1, 2014. The treating physician notes that the IW is receiving medication from several different physicians. Current complaints documented on September 4, 2014 include: 1. Intermittent moderate pain in his neck with radiation to both shoulders with occasional difficulty in rotating his head and neck. 2. Intermittent moderate pain in the left jaw. 3. Intermittent moderate pain in the right eye socket. 4. Intermittent moderate pain in both shoulders. 5. Intermittent moderate pain in the clavicle. 6. Intermittent moderate pain in the left rib cage with inhalation as well as stress and anxiety and difficulty breathing on occasion. He is improved overall, however, he still has significant limitations. His primary complaint is mechanical low back pain that is secondary to tertiary issue that is now presenting more significantly after having addressed the neck and left upper extremity. His primary mechanical low back symptoms are limiting his activities of daily living as well as his ability to exercise, or even get out of bed, run errands, drive a car, personal hygiene, etc. Current diagnose include: Status-post cervical fusion, persistent left upper extremity numbness related to the shoulder and the proximal arm, progressive mechanical lower back pain, right sciatica, and right radiculopathy with sensory deficits in the L5 distribution. Recommendations: Authorization for an epidural steroid injection and facet injection to the lumbar spine at L2-L3, L3-L4, L4-L5, and L5-S1. Continue authorization for medication including Naprosyn, Hydrocodone, and Omeprazole. The IW has a positive history for high blood pressure, anemia, and stomach ulcers. He denies any history of asthma, diabetes mellitus, arthritis, lung disease, epilepsy, tuberculosis, asthma, hepatitis, thyroid disease, collagen disease or cancer. The IW denies any other serious illnesses.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the lumbar spine without contrast: 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, Lumbar and Thoracic MRIs

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 pain; Magnetic Resonance Imaging

Decision rationale: Pursuant to the Official Disability Guidelines, repeat MRI of the lumbar spine is not medically necessary. The ODG guidelines state a repeat MRI is not routinely recommended. It should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (fracture, compression, recurrent disc herniation). In this case, the injured worker underwent lumbar MRI July 30, 2013 which his treating doctor states is consistent with recent x-rays. The medical record does not show any new focal neurologic deficits in the lower extremities. Furthermore the medical record does not show a significant change in clinical symptoms and/or objective findings suggestive of significant pathology. There are no red flags and no new recent trauma(s) addressed in the medical record. Based on the clinical information in the medical record and evidence-based, peer-reviewed guidelines, repeat MRI of the lumbar spine is not medically necessary.