

Case Number:	CM14-0212677		
Date Assigned:	12/30/2014	Date of Injury:	06/14/1998
Decision Date:	02/27/2015	UR Denial Date:	12/09/2014
Priority:	Standard	Application Received:	12/19/2014

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. 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 records presented for review indicate that this 60-year-old gentleman sustained an injury on June 14, 1998. The mechanism of injury was stated to be a fall from a ladder which resulted in a left patellar fracture. The most recent orthopedic progress note is dated November 24, 2014 and includes complaints of cervical spine pain with symptoms rating to the shoulders and down both arms. Previous treatment has included the use of anti-inflammatory medications and gabapentin without significant relief. There was also a complaint of low back pain radiating to the lower extremities. The physical examination on this date reveals a posture with the head and neck slightly hunched forward. There was decreased cervical spine range of motion with pain and a positive Spurling's test to the left greater than right side. Slightly decreased muscle strength was noted bilaterally in the biceps and triceps and there was a description of numbness bilaterally in the index and middle fingers. There was no evidence of hyperreflexia, clonus, or a Hoffman's sign. A physical examination of the lumbar spine reveals an antalgic gait favoring the left lower extremity. There was no tenderness over the lumbar spine region and full lumbar range of motion but with pain. Hamstring tightness was also noted and there was a normal lower extremity neurological examination. An MRI of the cervical spine dated March 24, 2014 reveals multilevel degenerative spondylosis most prominent at C4 - C5, C5 - C6, and C6 - C7 with severe left-sided neural foraminal stenosis at C6 - C7.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Lumbar without contrast: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287.

Decision rationale: ACOEM guidelines support ordering of imaging studies for emergence of red flags, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. I respectfully disagree with the UR physician's assertion that there are no neurological symptoms which merit an MRI, as the injured worker's refractory sciatica could be neuropathic in nature and amenable to procedural management, for which an MRI would be required. The request is medically necessary.