

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0065466 | | |
| Date Assigned: | 04/13/2015 | Date of Injury: | 02/16/1998 |
| Decision Date: | 05/19/2015 | UR Denial Date: | 03/25/2015 |
| Priority: | Standard | Application Received: | 04/06/2015 |

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

Certification(s)/Specialty: Preventive Medicine, Occupational 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 46 year old male, who sustained an industrial injury on February 16, 1998. The injured worker has been treated for neck and back complaints. The diagnoses have included left lumbar five and sacral one radiculopathy, rule out lumbar intradiscal component, major depression with psychotic features, chronic pain and rule out cervical radiculopathy. Treatment to date has included medications, radiological studies, electrodiagnostic studies and psychiatric evaluations. Current documentation dated February 6, 2015 notes that the injured worker reported neck pain with radiation to the bilateral upper extremities, left greater than the right. He also noted low back pain with radiation to the right lower extremity. Examination of the lumbar spine revealed tenderness, a decreased range of motion and a positive straight leg raise test bilaterally. Examination of the cervical spine revealed a decreased range of motion. The upper extremity neurologic evaluation was unchanged. The treating physician's plan of care included a request for an MRI of the lumbar spine as an outpatient and an office visit with a psychiatrist as an outpatient to address reactive depression.

IMR ISSUES, DECISIONS AND RATIONALES

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

One MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 297, 303, 304, 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter/MRI (Magnetic Resonance Imaging) Section.

Decision rationale: The MTUS Guidelines do not recommend the routine use of MRI with low back complaints. MRI should be reserved for cases where there is physiologic evidence that tissue insult or nerve impairment exists, and the MRI is used to determine the specific cause. MRI is recommended if there is concern for spinal stenosis, cauda equine, tumor, infection or fracture is strongly suspected, and x-rays are negative. The ODG recommends 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 patient has a documented history of prior lumbar MRI. The report was not submitted for review. Interim neurological changes that may indicate the need of a repeat study are not noted. The request for one MRI of the lumbar spine is determined to not be medically necessary.

Office visit with psychiatrist, outpatient, to address reactive depression: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine, 2nd edition: Chapter 7; Independent Consultations, pg 127.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 78, 79, 90.

Decision rationale: Per the MTUS Guidelines, the clinician acts as the primary case manager. The clinician provides medical evaluation and treatment and adheres to a conservative evidence-based treatment approach that limits excessive physical medicine usage and referral. The clinician should judiciously refer to specialists who will support functional recovery as well as provide expert medical recommendations. Referrals may be appropriate if the provider is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or agreement to a treatment plan. The injured worker has been diagnosed with major depression with psychotic features. At the injured worker's most recent Psychiatric appointment he had a subjective increase in anxiety and was placed on Valium and advised to continue psychotherapy and all other medications. The request for office visit with psychiatrist, outpatient, to address reactive depression is determined to be medically necessary.