

Case Number:	CM15-0071399		
Date Assigned:	04/21/2015	Date of Injury:	02/08/2006
Decision Date:	05/21/2015	UR Denial Date:	03/24/2015
Priority:	Standard	Application Received:	04/15/2015

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: Internal 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 51 year old male, who sustained an industrial injury on February 8, 2006. He reported repetitive use of a cutting machine with neck pain. The injured worker was diagnosed as having postoperative cervical spine fusion, cervical spine herniated nucleus pulposus (HNP) with radiculopathy, right carpal tunnel syndrome, tight shoulder postoperative arthroscopy with continued symptomology, lumbar spine herniated nucleus pulposus (HNP), bilateral plantar fascia, secondary dental decay due to prolonged medication use, medication induced gastritis, secondary depression, secondary sleep deprivation, and left testicular pain. Treatment to date has included physical therapy, x-ray, left shoulder injection, cervical fusion, right shoulder surgery, and medication. Currently, the injured worker complains of progressively worsening cervical and lumbar spine pain, headaches, with constant numbness into the left upper extremity with numbness and tingling, right wrist and hand pain, right elbow pain, depression, increased low back pain that radiates into his right lower extremity with numbness and tingling, medication induced gastritis, dental decay from prolonged medication use, bilateral plantar pain, and difficulty sleeping due to increased pain. The Primary Treating Physician's report dated March 6, 2015, noted the physical examination showed the cervical spine spinous process with tenderness and paravertebral muscle spasms bilaterally, with positive bilateral cervical distraction, maximum compression, and shoulder depression tests. The right upper extremity AC joint and bicipital groove were noted to be positive. The thoracolumbar spine evaluation was noted to show bilateral paravertebral muscle spasms and spinous process tenderness, with positive Patrick Fabere's and Kemp's tests bilaterally and positive bilateral

straight leg raise. The treatment plan was noted to include physical therapy for the cervical and lumbar spine, MRI of the cervical and lumbar spine, pain management evaluation, and dental evaluation.

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: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 289,290,303,304.

Decision rationale: The AECOM states that in the absence of "red flag" warning symptoms imaging and further testing are usually not helpful in the first 4 to 6 weeks of presentation of acute lumbar pain. Indiscriminate use of MRI exams often result in false positive findings such as disc bulges which do not cause symptoms or warrant surgical consideration. Symptoms which point toward the following disorders; fracture, tumor, infection, the cauda equina syndrome, or progressive neurological deficit; would be considered to be "red flag warnings." Unequivocal objective findings demonstrating nerve compromise on exam and where surgery would be considered as a therapeutic option is sufficient evidence to image patients with an MRI or other radiological exams if conservative treatment has failed. MRI scanning is utilized when neural or soft tissue pathology is suspected and CT scan is often utilized when bony structures are suspected to be the problem. Also MRI studies may be utilized in order to help in diagnosis of problems that do not need surgery such as sciatica caused by the piriformis syndrome in the hip. MRI imaging is especially useful in the diagnosis of disc protrusion, cauda equine syndrome, spinal stenosis, and post laminectomy syndrome. In this particular patient we have chronic lumbar disc prolapse diagnosed and conservative treatment has failed to improve the symptomatology. In fact, the symptoms have progressed and exacerbated. The patient also presents with nerve root signs which corroborate the diagnosis of prolapsed lumbar disc. If the test is markedly positive consideration to a surgical correction should be considered. Thus, it is medically indicated that the patient have an MRI of the lumbar spine. The request IS medically necessary.