

Case Number:	CM14-0030953		
Date Assigned:	06/20/2014	Date of Injury:	09/26/2011
Decision Date:	09/25/2015	UR Denial Date:	03/05/2014
Priority:	Standard	Application Received:	03/11/2014

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: North Carolina

Certification(s)/Specialty: Family Practice

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 sustained an industrial injury on 9-26-11. His initial complaints and the nature of the injury are unavailable for review. He has diagnoses of status post C4-5, C5-6 anterior cervical fusion for spinal cord decompression and anterolisthesis, status post L3-4, L4-5 laminectomy, recent onset of Devic's Syndrome with severe transverse myelitis mid-thoracic with lower extremity paraparesis, demyelination confirmed, depression and anxiety, BMI 40, hypertension, insulin-dependent diabetes, sleep apnea, peripheral edema, COPD, lower extremity tremor at rest and intention on the left, situational adjustment reaction, history of lower extremity skin breakdown, recent self-catheterization program for urinary retention and atonic bladder, and difficulty with pain management. On 2-4-15, he presented to the neurological provider. The report states "he continues to struggle with paraparesis and wheelchair condition from Devic's Disease, transverse myelitis with optic atrophy". The report indicates that physical therapy was "non-beneficial". It also indicates that his family was concerned about persistent tremor in the left lower extremity. It was also noted that his "myelopathy has worsened and his right lower extremity is now completely flaccid". The injured worker was noted to be wheelchair-bound and unable to transfer. The treatment plan included advising the injured worker to quit smoking, monitor blood pressure at least three times daily, and continue self-catheterization. Prescriptions of Baclofen, OxyContin, and Oxycodone were given for treatment of lumbar and cervical back pain. A request for MRI of "the entire spine" was made to determine if there is progression of lumbar spine industrial disc disease or cervical spine disc disease. This was requested due to progressive lower extremity weakness.

IMR ISSUES, DECISIONS AND RATIONALES

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

Magnetic Resonance Image (MRI) of the Cervical Spine,: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

Decision rationale: The ACOEM chapter on neck and upper back complaints and special diagnostic studies states: Criteria for ordering imaging studies are: Emergence of a red flag. Physiologic evidence of tissue insult or neurologic dysfunction. Failure to progress in a strengthening program intended to avoid surgery. Clarification of the anatomy prior to an invasive procedure. The provided progress notes fails to show any documentation of indications for imaging studies of the neck as outlined above per the ACOEM. There was no emergence of red flag. The neck pain was characterized as unchanged. The physical exam noted no evidence of new tissue insult or neurologic dysfunction. There is no planned invasive procedure. Therefore, criteria have not been met for a MRI of the neck and the request is not medically necessary.

Magnetic Resonance Image (MRI) of the Thoracic Spine,: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 11th edition (Web 2014), Low Back, and MRI.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 177-178.

Decision rationale: The ACOEM chapter on neck and upper back complaints and special diagnostic studies states: Criteria for ordering imaging studies are: Emergence of a red flag. Physiologic evidence of tissue insult or neurologic dysfunction. Failure to progress in a strengthening program intended to avoid surgery. Clarification of the anatomy prior to an invasive procedure. The provided progress notes fails to show any documentation of indications for imaging studies of the thoracic spine as outlined above per the ACOEM. There was no emergence of red flag. The back pain was characterized as unchanged. The physical exam noted no evidence of new tissue insult or neurologic dysfunction. There is no planned invasive procedure. Therefore, criteria have not been met for a MRI of the thoracic spine and the request is not medically necessary.

Magnetic Resonance Image (MRI) of the Lumbar Spine,: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

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

Decision rationale: The ACOEM chapter on low back complaints and special diagnostic studies states: Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures). Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false positive test results) because of the possibility of identifying a finding that was present before symptoms began and therefore has no temporal association with the symptoms. Techniques vary in their abilities to define abnormalities (Table 12-7). Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Because the overall false-positive rate is 30% for imaging studies in patients over age 30 who do not have symptoms, the risk of diagnostic confusion is great. There is no recorded presence of emerging red flags on the physical exam. There is evidence of nerve compromise on physical exam but there is not mention of consideration for surgery or complete failure of conservative therapy. For these reasons, criteria for imaging as defined above per the ACOEM have not been met. Therefore, the request is not medically necessary.