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| Case Number: | CM13-0019050 | | |
| Date Assigned: | 10/11/2013 | Date of Injury: | 10/04/2004 |
| Decision Date: | 01/15/2014 | UR Denial Date: | 08/21/2013 |
| Priority: | Standard | Application Received: | 09/03/2013 |

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in internal medicine, has a subspecialty in pulmonary diseases, 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 physician 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.

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 patient is a 64-year-old who reported an injury on 10/04/2004. The claimant was reportedly pushing a patient on a gurney, and tried to exert more energy when the gurney was not working well and subsequently injured her lower back. The patient has already undergone an L5-S1 fusion in 09/2005, as well as 17 postoperative physical therapy visits. An MRI from 03/2010 showed an old compression fracture at the L2 vertebral body, a solid surgical fusion and laminectomy at the L5-S1 level with no central or foraminal stenosis, and mild degenerative disc bulges and facet hypertrophy from L2-3 through L4-5 resulting in central and foraminal stenosis. An undated EMG (electromyogram) was reportedly performed, with benign findings. In 01/2008, the patient underwent an S1 transforaminal epidural steroid injection, but reported not having much relief. The patient was most recently seen in 08/2013, with the same complaints of chronic low back pain and bilateral lower extremity pain. On these clinical notes it stated the patient is slow to transfer between sitting and standing, is ambulating with a single point cane, and she has decreased lumbar spine range of motion in both flexion and extension. The physician is now requesting a repeat MRI of the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

A pre-operative MRI on the lumbar spine without contrast: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308 - 310..

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 309..

Decision rationale: The Physician Reviewer's decision rationale: According to the Low Back Complaints chapter of the ACOEM Practice Guidelines, an MRI is the test of choice for patients with prior back surgery. As noted in the documentation, the patient has undergone a previous cervical spine fusion, and is still having unrelenting chronic back pain. The documentation further states that the patient has undergone plain view x-rays of the lumbar spine which revealed collapse of the L4-5 disc space. The patient has also tried multiple forms of treatment modalities with no exceptional relief noted. Therefore, due to the patient having already utilized several forms of conservative treatment without relief of her chronic lumbar back pain, an additional MRI of the lumbar spine would be considered an appropriate step in helping to diagnose the patient's current medical condition. The request for a pre-operative MRI on the lumbar spine without contrast is medically necessary and appropriate.