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| Case Number: | CM13-0050148 | | |
| Date Assigned: | 12/27/2013 | Date of Injury: | 01/07/1992 |
| Decision Date: | 03/18/2014 | UR Denial Date: | 10/22/2013 |
| Priority: | Standard | Application Received: | 11/11/2013 |

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 Pain Medicine & Rehabilitation, has a subspecialty in Interventional Spine 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. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 46 year old female with date of injury 1/7/92. The treating physician report dated 8/28/13 indicates that the patient continues with lower back and right leg pain. The report also states that the "patient has not had MRI done yet." The listed diagnosis was Sciatica. The 10/22/13 utilization review report denied the request for MRI of L-spine with contrast stating lack of documentation of the failure of recent conservative treatment attempts and lack of current objective neurological exam findings suggestive of nerve root impingement or cord pathology.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 MRI with contrast, lumbar 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 (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Decision rationale: The patient presents with complaints of worsening lower back and right leg pain. The current request is for an MRI with contrast of the L-spine with the statement that the "patient has not had MRI done yet." Review of the reports would reveal that the patient did have

an MRI of L-spine on 3/4/12 showing solid fusion at L5-1 with bilateral foraminal stenosis and 4mm spondylolisthesis. Examination from 8/28/13 indicates that the patient walks with a limp, has tenderness in the piriformis area, has negative SLR, normal lumbar motion that is pain free. The assessment is stable sciatica and the plan states "since her pain is worsening, we will try to get auth for a new MRI lumbar spine with IV contrast to rule out worsening stenosis or narrowing." The MTUS guidelines and ACOEM do not discuss repeat MRI's or MRI's following history of lumbar surgery. ODG guidelines state "Recommended for indications below. MRI's are test of choice for patients with prior back surgery, but for uncomplicated low back pain with radiculopathy, not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation)." In this case, the treater appears to be recommending a routine MRI based on the patient's symptoms. Examinations do not show any neurologic progression, no new symptoms are present other than subjective worsening of pain that is common among chronic pain patients. There is no new injury and there is no planning for additional surgery. The patient already had a set of post-operative MRI of L-spine on 3/4/12 that showed solid fusion at L5-S1. The guidelines do not support routine MRI's in the absence of "significant change in symptoms and/or findings suggestive of significant pathology. Such is not demonstrated in this patient. Recommendation is for denial.