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| Case Number: | CM13-0067780 | | |
| Date Assigned: | 01/03/2014 | Date of Injury: | 12/05/2008 |
| Decision Date: | 05/29/2014 | UR Denial Date: | 12/06/2013 |
| Priority: | Standard | Application Received: | 12/18/2013 |

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. The expert reviewer is Board Certified in Occupational Medicine, has a subspecialty in Preventive Medicine, 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 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/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:

Patient is a 56 year old female with date of injury 12/05/2008. The medical report associated with the request for authorization, a primary treating physician's progress report, dated 11/25/2013, lists subjective complaints as neck, low back and upper extremity pain. The patient noted that she has been experiencing a gradual increase of lower back pain. She experiences weakness and numbness throughout her bilateral lower extremities and she did sustain a fall. Objective findings: Examination of the lumbar spine revealed a normal gait and normal lordosis with no scoliotic deformity. Deep tendon reflexes were symmetrical bilaterally to the patella and Achilles. There was no clonus sign noted bilaterally. There was normal lumbar flexion, extension, bilateral lateral bending and rotation to the right and left. Sensation was intact to light touch and pinprick bilaterally to the lower extremities. No spasm or guarding was noted. Lumbar motor strength was 5/5 to hip flexion, hip extension, knee extension, knee flexion, ankle eversion, ankle inversion and extensor hallucis longus. Diagnosis: 1. Cervical disc displacement without myelopathy 2. Degeneration, cervical disc 3. Degeneration, lumbar disc 4. Disorders, sacrum. The medical records provided for review did not contain any report of any recent lumbar MRI. There is reference in several reports to a lumbar MRI dated 07/23/2009. No radiologist's report is present in the medical record; however, the MRI report as ready to a QME evaluation is as follows: 1. Mild spondylitic changes at L4-5 and L5-S1; 2. Congenital and degenerative type moderate to marked central spinal canal stenosis at L4-5 and L5-S1 due to combination of short pedicles, disc bulges, facet joint arthropathy, and ligamentum flavum hypertrophic changes.; 3. Additional posterior central disc protrusion and annular tear at L5-S1 contributes to spinal canal stenosis.; 4. Minimal disc desiccation and disc bulges at other levels.

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: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Indications for MRI.

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

Decision rationale: The patient underwent a permanent impairment evaluation on 03/21/2013. The future medical treatment section of the report makes provision for future lumbar surgery due to the patient having bilateral lower extremity radiculopathy and evidence of spinal stenosis on MRI. It is noted in a progress note by her primary treating physician on 10/31/2013; however, that the patient is not interested in invasive or surgical procedures and would like to treat her pain conservatively. Since leaving a comprehensive functional restoration and pain management program, the patient has had very little recorded change in her low back and leg symptoms. In addition, the most recent neurologic examination in regard to her lumbar spine is relatively normal. Considering the above factors and referencing the MTUS, an MRI of the lumbar spine is not medically necessary at this time.