

Case Number:	CM13-0071645		
Date Assigned:	01/17/2014	Date of Injury:	12/20/2005
Decision Date:	06/16/2014	UR Denial Date:	12/05/2013
Priority:	Standard	Application Received:	12/24/2013

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 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:

The patient is a 58 year old male who was injured on 12/20/2005. The patient reportedly tripped and fell on steps, 4 feet, landing on his left knee resulting in injury to his left knee and ankle. Prior treatment history has included the following medications: 1. Norco 10/325 mg 2. Voltaren 100 mg 3. Neurontin 300 mg 4. Prilosec 20 mg 5. Rx topical compound cream PR-2 dated 08/30/2013 documented that the provider had requested medical records to clarify the injury and treatment history. It was implied that from interventional pain management standpoint the patient might benefit from this type of treatment after reviewing the medical records and previous imaging studies. The plan was if no current studies were available it would be medically necessary to request updated imaging studies. X-rays of the left knee and L/S to r/o fractures after his slip and fall aggravation injury on 08/06/2013. Further, it was implied that the patient would likely need new MRI studies of his L knee and L/S, as the patient indicated that his last studies were approximately 4 years ago. PR-2 dated 09/23/2013 documented that lumbar and left knee MRI without contrast was requested. PR-2 dated 10/21/2013 documented the patient was doing better since his last visit. It was implied that the patient was back to his baseline in terms of his regular pain condition. He still had regular low back pain associated with shooting pain down into left leg. He complained of pain to left knee. He continued to struggle with long distance walking. The pain pattern was not changed which was described as sharp, stabbing and miserable. Patient said that on an average the pain was 8/10. The pain was aggravated with movement. He also reports left ankle problems with pain and swelling. Objective findings on exam revealed no deformity and no visible atrophy in the upper or lower limbs by gross inspection. There was no swelling in the bilateral lower extremities. There was tenderness to palpation of the left knee. Examination of the back revealed no surgical scar on lower back. There was no evidence of scoliosis. ROM in lumbar spine was unable to be determined due to

severity of pain. Diagnoses: 1. Chronic low back pain 2. Left knee status post arthroscopy surgery 3. Ambulation-assistive device dependent 4. Left ankle Treatment Plan: Request lumbar, left knee and left ankle MRI without contrast. Continue Norco 10/325 6/d prn for flaring up pain, Voltaren 100 mg 1 Bid, Neurontin 300 mg tid and Prilosec 20 mg 1 bid and topical compounded pain cream. 11/25/2013 - Utilization review report indicated that a lumbar MRI was authorized by the adjustor in May 2012 and the results of that MRI have not been established. Also, it should be noted that 12/20/2011 - AME report documented that the MRI demonstrated two levels of abnormality with the spine. The date of this MRI study was not mentioned.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-316, 303-304. Decision based on Non-MTUS Citation SECTION ON IMAGING OF THE LOW BACK; ODG TWC 2013, LOW BACK, LUMBAR/THORACIC: MRI (MAGNETIC RESONANCE IMAGING).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: As per CA MTUS/ACOEM guidelines, "When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study." The Official Disability Guidelines (ODG) recommends repeat MRI for significant change in symptoms and/or findings suggestive of significant pathology (e.g. Tumor, infection, fracture, neurocompression, recurrent disc herniation). The medical records document 10/21/2013 report documented that the patient was at baseline with pain. The records do not identify any red flags or progressive neurologic deficits to substantiate the request for a repeat MRI of the lumbar spine. Further, 12/20/2011, AME report documented that "MRI demonstrated two levels of abnormality with the spine. Also, a lumbar MRI was authorized by the adjustor in 05/2012. It should also be noted that the provider had been seeing the patient for over a year and during that time the patient had not received Physical Therapy. Based on the Official Disability Guidelines (ODG) guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.