MAXIMUS Federal Services

Case Number:	CM14-0002254		
Date Assigned:	01/24/2014	Date of Injury:	10/30/2000
Decision Date:	10/01/2014	UR Denial Date:	12/17/2013
Priority:	Standard	Application Received:	01/07/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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 injured worker is a 52 year old male who reported an injury on 10/30/2000. The mechanism of injury was not provided. His diagnoses were noted as lumbar disc disease, lumbar radiculitis, post laminectomy syndrome, and cervical radiculopathy. The past treatments included lumbar epidural injections, diagnostic facet injections, chiropractic treatment and physical therapy. His diagnostic studies were noted to include unofficial x-rays of the lumbar spine in 2008, EMGs,most recently in 2010 which were noted to reveal positive L5 radiculopathy and severe neuropathy. There was also a previous lumbar spine MRI on 06/26/2009 which was noted to reveal bilateral foraminal stenosis and grade I spondylolisthesis, and a lumbar spine MRI on 03/22/2010 which was noted to show L3-S1 posterior decompression and bilateral pedicle screws at L3, L4, L5 and S1. His surgical history includes the removal of bone growth stimulator on 07/19/2010, removal of hardware on 04/19/2011, and a repeat laminotomy and foraminotomy at L4-L5 and L5-S1. On 12/05/2013, the injured worker complained sharp low back pain that caused weakness in his lower extremity. He reported his pain had resolved with ibuprofen and rest, but he was concerned about performing his activities of daily living due to apprehension of the pain returning. Upon physical examination, the injured worker was noted to have weakness of his left ankle dorsiflexors consistent with a foot drop. His medication was listed as Nucynta 75 mg. The treatment plan was to request x-ray of lumbar spine and sacrum and to request an open MRI of lumbar spine and sacrum. The rationale for the request was to evaluate his soft tissue status. The request for authorization form was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI FOR LUMBAR SPINE (REPEAT): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM, CHAPTER 12 (LOW BACK COMPLAINTS), 303-304

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)), Low Back, MRIs (magnetic resonance imaging).

Decision rationale: The request for MRI for lumbar spine (repeat) is not medically necessary. The Official Disability Guidelines state repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The injured worker reported that his pain has resolved with ibuprofen and rest. A lumbar spine MRI dated 03/22/2010 was noted to show L3-L4 to S1 posterior decompression and bilateral pedicle screws at L3, L4, L5, and S1. However, the MRI report was not provided to verify these findings. Although, the clinical documentation noted weakness to the left ankle dorsiflexors consistent with a foot drop, there was not sufficient objective evidence of significant neurological deficits, such as decreased motor or sensation in a specific distribution, or findings representing a significant change in clinical presentation since the time of his previous MRI. In the absence of a significant change in symptoms and/or findings suggestive of significant pathology, the request is not supported. Therefore, the request is not medically necessary.