

Case Number:	CM14-0081436		
Date Assigned:	07/18/2014	Date of Injury:	09/08/2005
Decision Date:	09/18/2014	UR Denial Date:	05/19/2014
Priority:	Standard	Application Received:	06/02/2014

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 Anesthesiology, licensed Acupuncturist, has a subspecialty in Pain Management 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:

This is a 53 year old female injured worker with date of injury 9/8/05 with related lumbar spine and left knee pain. Per progress report dated 5/1/14, it was noted that her left knee pain was found out of proportion to objective findings by her orthopedist. The pain in the low back radiated down both hips and legs, left worse than right, with concentration of the pain into the left knee. She also complained of experiencing electric shocks into the big toe on the right side. Per physical exam, the injured worker had difficulty rising from a sitting position. She limped and used a cane. Tip-toe and heel walking were not able to be done. Range of motion of the lumbar spine was reduced to less than 50% of normal. All muscle groups tested in the lower extremities were 4+/5 in the proximals and 4/5 in the distals. Deep tendon reflexes were absent. MRI of the lumbar spine dated 12/28/12 revealed degenerative changes and spondylolisthesis with no evidence of a disc herniation in the setting of obviously congenital scoliosis. MRI of the lumbar spine performed 2/22/13 revealed moderate lower lumbar levoscoliosis, centered at L3, with leftward displacement of L4 on L5 by 7.5mm. At L3-L4 there was a mild right central disc bulge with minimal right foraminal extension and minimal spinal canal narrowing. At L4-L5 there was a mild right central disc bulge with minimal bilateral foraminal extension and minimal spinal canal narrowing with mild annular bulges at L1-L2, L2-L3, and L5-S1 with no spinal canal or neural foraminal narrowing. She was status post ACL reconstruction in 11/2006, and another surgery in 12/2010, and in 2011, removal of hardware. Treatment to date has included injections, knee brace, physical therapy, and medication management. The date of UR decision was 5/19/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar MRI without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177.

Decision rationale: ACOEM guidelines support ordering of imaging studies for emergence of red flags, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The injured worker has had MRI of the lumbar spine in 2012 and 2/2013, as well as MRI scans of the knees in 2006, 2007, 2009, and 2013. As there was no significant injury or change in the injured worker's clinical presentation, the medical necessity of repeat MRI is not supported. The request is not medically necessary.