

<b>Case Number:</b>	CM14-0172803		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	06/18/2003
<b>Decision Date:</b>	01/14/2015	<b>UR Denial Date:</b>	10/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/20/2014

### 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 and Rehabilitation 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 injured worker has a date of injury of 6/16/03. Treatment diagnoses include failed back syndrome status post spinal cord stimulator removal and depression. Upon post-operative follow up the patient was noted to have left anterior thigh numbness, and 4+/5 motor at the left hip abductors and flexors. There are no abnormalities on post-operative x-rays reported. There was concern of an adjacent level disc protrusion and with the removal of the spinal cord stimulator the patient is now candidate for MRI evaluation. On 9/23/14 request was made for thoracolumbar MRI without contrast.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **MRI Thoracic/Lumbar Spine without Contrast: 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), Low Back chapter: Indications for Imaging: MRI

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315.

**Decision rationale:** The injured worker presents with post laminectomy syndrome and suspected upper lumbar radiculopathy secondary to herniated disc. Records indicate that signs and

symptoms are primarily on the left side with corresponding sensory deficits and motor weakness above the level operated on- thus adjacent to the fusion. MTUS guidelines criteria indicate that MRI is indicated for the diagnosis of disc protrusion and post laminectomy syndrome. Records document that the symptoms have persisted for greater than 6 weeks. Therefore, the request for MRI is medically necessary.