

<b>Case Number:</b>	CM14-0189026		
<b>Date Assigned:</b>	11/19/2014	<b>Date of Injury:</b>	04/02/2009
<b>Decision Date:</b>	01/08/2015	<b>UR Denial Date:</b>	11/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/12/2014

### 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 Family 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:

This 53-year old man reported an injury of his low back with a date of 4/2/09. No information about the mechanism of injury is contained in the available records. Treatment has included medications, physical therapy and multiple back surgeries, including a lumbar decompression at L3-4 and L4-5, a fusion at the same levels in 2/12 and a redo fusion in 10/13. He has remained symptomatic and totally disabled, and has continued to require opioid medication. An MRI with and without contrast performed on 4/18/14 revealed stable postoperative changes at the L3-4 and L4-5 levels, with progressive changes at the L2-3 level with facet arthropathy and disc bulging resulting in moderate to severe central and right lateral foraminal stenosis. There is a mild disc bulge at L5-S1 which does not cause neural compromise. The records contain three notes from the patient's primary treater, a neurosurgeon, which begin on 6/13/14. They document back pain which radiates to both legs and feet, worse on the right. Minimal exam findings are recorded, with none at all on 6/13/14. A right L2-3 epidural steroid injection was performed on 6/26/14. The following visit, 7/31/14 notes that the patient's ability to walk has increased, and that he walks around the block 3-4 times per day. Exam findings include a normal gait and motor exam. By 10/6/14 the patient's pain has increased to the point where he is only able to walk one block, and is unable to sleep due to pain. Documented exam findings include only that he has difficulty arising from a sitting position, and has an antalgic gait with a forward lurch. The plan at this visit includes ordering new x-rays and MRIs to assess the status of the fusion and the segments nearby. The provider states that he is likely to refer the patient to a tertiary care center for a second opinion if the fusion has failed. The patient's opioid was changed from Norco to Dilaudid at this visit. A lumbosacral spine series with flexion and extension views was performed on 10/23/14. The report from this study documents 5 mm spondylolisthesis at L2-3 with flexion and 6 mm with extension, with no other acute bony abnormalities. Fusion hardware is noted. The UR

report dated 11/11/14 refers to a primary treater's progress note dated 10/28/14 which is not contained in the available records. According to the UR report, that visit involved reviewing the 10/23/14 x-rays. The physician is reported as documenting that there "was not a lot of extreme lateral interbody fusion (XLIF) cages", that there might be bony bridging in the periphery, and that there was spondylolisthesis at the L2-3 segment. Diagnoses included "fusion failure or other mechanical compromise of other internal orthopedic device, implant or graft". Requests for lumbosacral CT scan, MRI without contrast, and MRI with and without contrast were made. CT scan and MRI without contrast were approved in the 11/11/14 UR. The MRI scan with and without contrast was denied on the basis that the need for contrast had not been demonstrated.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**MRI lumbar with and without GAD:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official disability Guidelines -MRI

**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 chapter, MRI's Other Medical Treatment Guideline or Medical Evidence: American College of Radiology Appropriateness Criteria, Low Back Pain, Prior Lumbar Surgery

**Decision rationale:** The ODG reference cited above states that MRI's are the test of choice for patients with low back pain and prior back surgery, and also the test of choice for suspected myelopathy. The ACR reference states that MRI with and without contrast is the most appropriate test for a patient with low back pain and prior back surgery, as it can distinguish between scar tissue and disc. The clinical documentation in this case, while limited, supports the performance of an MRI with and without contrast. This patient has severe, increasing back pain with radiation to both legs after multiple previous back surgeries. In addition to failed fusion, myelopathy would definitely be a concern and the most appropriate test for it would be MRI with and without contrast. According to the evidence-based citations above and the clinical documentation available for my review, an MRI with and without contrast IS medically necessary. It is the most appropriate test to evaluate worsening pain and possible myelopathy in a patient who has had multiple spinal surgeries.