

<b>Case Number:</b>	CM14-0204438		
<b>Date Assigned:</b>	12/16/2014	<b>Date of Injury:</b>	10/08/2008
<b>Decision Date:</b>	02/05/2015	<b>UR Denial Date:</b>	12/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/08/2014

### 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 Internal 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 injured worker (IW) is a 43-year-old man with a date of injury of October 8, 2008. The mechanism of injury was not documented in the medical record. The injured worker's working diagnoses are status post L5-S1 fusion on July 27, 2012, and cervical disc bulge. A prior MRI of the lumbar spine dated October 3, 2013 reveals straightening of the lumbar spine; surgically fused L5-S1 level; single level posterior fixation device is seen spanning L5 and S1 vertebra; laminectomy defect noted at L5-S1 level; interbody spacer device is noted at L5-S1 level; post-surgical changes noted along the posterior subcutaneous tissue and paraspinal musculature at lower lumbar levels; intact hardware; L3-L4 diffuse disc protrusion with effacement of the thecal sac. Neuroforaminal narrowing without significant impingement of existing nerve roots; L4-L5 diffuse disc protrusion compressing the thecal sac. Bilateral neural foraminal stenosis that encroaches the left and right L4 exiting nerve roots; L5-S1 is surgically fused. Posterior disc osteophyte complex effacing the thecal sac. Bilateral neural foraminal narrowing noted; and grade I retrolisthesis of L3 over L4, L4 over L5, and L5 over S1 noted. A CT scan of the lumbar spine dated January 31, 2012 revealed moderate to severe degenerative disc disease and narrowing of L5-S1 interspace associated with posterior spondylitic ridging with osteophytic encroachment into the bilateral neural foramina causing moderate bilateral foraminal stenosis. No acute processes noted and in particular there is no evidence of fracture as clinical suspected. No spondylosis or spondylolisthesis is noted. Pursuant to a progress reports dated November 11, 2014, the IW complains of low back pain with right leg numbness and tingling. He reports the cervical spine pain is worse than the lumbar spine pain. Physical examination reveals tenderness to the paraspinals at L4-S1. Positive straight leg raise test on the right is noted. Range of motion is 60 degrees with end-range pain. The IW ambulates with a cane. There was no focal neurologic deficits documented on exam. There is no documentation of any progressive deficit documented

in the medical record. The IW is status post L5-S1 fusion on July 27, 2012. The treating physician is requesting a new MRI of the lumbar spine and a new CT of the lumbar spine because the last diagnostics were done in 2012. The treating physician did not provide clinical rationale as to why he would like to repeat the MRI and CT of the lumbar spine. The current request is for MRI of the lumbar spine, and CT of the lumbar spine.

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

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

**MRI of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**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, MRI.

**Decision rationale:** Pursuant to the Official Disability Guidelines, MRI of the lumbar spine is not medically necessary. MRIs are the test of choice for patients with prior back surgery, but uncomplicated low back pain, with radiculopathy, not recommended until after at least one month conservative therapy sooner if progressive neurologic deficit. Repeat MRI is not the recommended and should be reserved for a significant change in symptoms and findings suggestive of significant pathology. The indications for magnetic resonance imaging are enumerated in the Official Disability Guidelines. They include, but are not limited to, lumbar spine trauma, neurologic deficit; uncomplicated low back pain, suspicion of cancer infection or other red flag; uncomplicated low back pain with radiculopathy, at least one month conservative therapy sooner if progressive neurologic deficit. See guidelines for specific details. In this case, a progress note dated November 11, 2014 provides a four line subjective and objective fill-in the blanks format for the injured worker. The injured worker had an MRI October 3 2013. MRIs significant results were a surgically fused L5 - S1 level; straightening of the lumbar spine; laminectomy defect at L5 - S1; interbody spacer device at L5-S1; postsurgical changes; hardware is intact; L3 - L4 and diffuse disc protrusion with effacement of fecal sac; L4 - L5 diffuse disc protrusion compressing thecal sac; L5 - S1 surgically fused; and grade 1 retrolisthesis L3 over L4. Progress note dated November 11, 2014 states tender paraspinal L4 - S1 with positive straight leg raising. There is no clinical indication or clinical rationale to repeat the MRI of the lumbar spine. As noted above, an MRI was performed October 3, 2013. Repeat MRI is not recommended and should be reserved for a significant change in symptoms and findings suggestive of significant pathology. There was no documentation indicating a significant change in symptoms or objective findings suggestive of significant pathology. Consequently, absent the appropriate clinical documentation indicating a significant change in symptoms or findings suggestive of significant pathology, a clinical indication or rationale to repeat the MRI, MRI evaluation lumbar spine is not medically necessary.

**CT of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- Indication for imaging

**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, CAT scan.

**Decision rationale:** Pursuant to the Official Disability Guidelines, CAT scan of the lumbar spine is not medically necessary. Magnetic resonance imaging has largely replaced computed tomography in the noninvasive evaluation of patients with painful myelopathy because of superior soft tissue resolution and multiplanar capability. The guidelines indicate imaging should be avoided without a clear rationale for doing so. There is no benefit to routine lumbar imaging for low back pain without indications of serious underlying conditions. See the Official Disability Guidelines for CAT scan imaging lumbar spine. In this case, a progress note dated November 11, 2014 provides a four line subjective and objective fill-in the blanks format for the injured worker. The injured worker had a CAT scan of the lumbar spine reviewed January 31, 2012. The results were notable for moderate to severe degenerative disc disease and narrowing of the L5 - S1 interspace with posterior spondylitic ridging and osteophytic encroachment into the bilateral neural foramina causing moderate bilateral foraminal stenosis. No acute processes were noted and there is no evidence of fracture. The injured worker had an MRI October 3, 2013. MRIs significant results were a surgically fused L5 - S1 level; straightening of the lumbar spine; laminectomy defect at L5 - S1; interbody spacer device at L5-S1; postsurgical changes; hardware is intact; L3 - L4 and diffuse disc protrusion with effacement of fecal sac; L4 - L5 diffuse disc protrusion compressing thecal sac; L5 - S1 surgically fused; and grade 1 retrolisthesis L3 over L4. Progress note dated November 11, 2014 states tender paraspinal L4 - S1 with positive straight leg raising. There is no clinical indication or clinical rationale to repeat the CAT scan of the lumbar spine. Imaging should be avoided without a clear rationale for doing so. There is no benefit to routinely perform lumbar imaging for low back pain without indications of serious underlying conditions. There was no documentation indicating a significant change in symptoms or objective findings suggestive of significant pathology. Consequently, absent the appropriate clinical documentation indicating a significant change in symptoms or findings suggestive of significant pathology, a clinical indication or rationale to repeat the CAT scan, CAT scan evaluation lumbar spine is not medically necessary.