

Case Number:	CM14-0209894		
Date Assigned:	12/22/2014	Date of Injury:	12/10/2008
Decision Date:	02/12/2015	UR Denial Date:	11/17/2014
Priority:	Standard	Application Received:	12/15/2014

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 58-year-old woman with a date of injury of December 10, 2008. The mechanism of injury occurred when she tripped and fell over carpet. She fell on her right hip and right knee. The injured worker's working diagnoses are status post lumbar fusion; severe degenerative disc disease at L5-S1 with severe foraminal stenosis; history fatty liver with elevated liver enzymes; bilateral sacroiliitis, right greater than left; left lumbar radiculopathy with severe L5-S1 foraminal stenosis and EMG evidence of chronic S1 left radiculopathy. Pursuant to the progress note dated October 15, 2014, the IW reports continued low back pain. Since her last visit, she has been approved for a spinal cord stimulator trial as of September 16, 2014. She does note her back pain is unchanged since last visit. Examination of the lumbar spine reveals midline scar. She has tenderness to palpation of her bilateral SI joints. Range of motion in the lumbar spine is decreased in all planes. Straight leg raise is positive on the left, which elicits numbness and tingling to the left lower extremity to the foot. Straight leg raise test on the right elicits pain extending to the posterior thigh. Motor examination is grossly normal and neurologic evaluation is notable for a bilateral lower extremity intact sensation examination. Current medications include Zohydro 10mg, Voltaren gel, Lidoderm patches, and Flexeril 7.5mg. The IW had an MRI evaluation October 13, 2013. Other progress notes in the medical record give the date of 2012 for the prior MRI. The injured worker's symptoms are unchanged. The current request is for repeat MRI of the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Magnetic Resonance Imaging (MRI) of the Lumbar Spine: 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)

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 Section, MRI Low Back.

Decision rationale: Pursuant to the Official Disability Guidelines, magnetic resonance imaging of the lumbar spine is not medically necessary. MRIs of the test of choice for patients with prior back surgery but, for uncomplicated low back pain, with radiculopathy, not recommended until at least one month conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neural compression, and recurrent disc herniation). See the Official Disability Guidelines for lumbar indications, magnetic resonance imaging. In this case, the injured worker's working diagnoses are status post lumbar fusion; severe degenerative disc disease at L5 - S1 with severe foraminal stenosis; history fatty liver with elevated liver enzymes; bilateral sacral ileitis; left lumbar radiculopathy with severe L5 - S1 foraminal stenosis and EMG evidence of chronic S1 left radiculopathy. The injured worker, pursuant to an October 15, 2014 progress note, presents for a follow-up low back pain visit. She admits her back pain remains "unchanged since her last visit". The dictation is notable for tenderness palpation of the bilateral SI joints. Range of motion is decreased in all planes. Mortar examination is grossly normal and neurologic evaluation is notable for a bilateral lower extremity intact sensation examination. The injured worker had an MRI evaluation October 13th of 2013. Other progress notes in the medical record given date of 2012 for the prior MRI. The injured worker symptoms are unchanged. Repeat MRI is not routinely recommended and is reserved for patients with the significant change in symptoms and/or findings suggestive of significant pathology. The injured worker offers no significant change in symptoms and no significant change in clinical objective signs. There is no request for a lumbar MRI scan in the progress note. Consequently, repeat MRI evaluation of the lumbar spine is not medically necessary.