

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0166571 | | |
| Date Assigned: | 09/04/2015 | Date of Injury: | 05/05/1989 |
| Decision Date: | 10/09/2015 | UR Denial Date: | 08/12/2015 |
| Priority: | Standard | Application Received: | 08/25/2015 |

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 is a 72 year old male, who sustained an industrial-work injury on 5-5-89. He reported initial complaints of low back pain with radiation to the right lower extremity. The injured worker was diagnosed as having lumbar degenerative disc disease and radiculopathy, facet joint pain, and lumbar laminectomy (9-17-14). Treatment to date has included medication, prior surgery, and diagnostics. Currently, the injured worker complains of low back pain that was achy and dull and rated 6-7 out of 10 with radiation to the right lower extremity. Per the primary physician's progress report (PR-2) on 8-1-15, exam noted tenderness in the low back and decreased deep tendon reflexes in the bilateral knees. Current plan of care includes Transforaminal epidural steroid injection and MRI (magnetic resonance imaging) of the lumbar spine. The requested treatment included MRI lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI lumbar spine: Overturned

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment for Workers' Compensation (ODG-TWC) Low Back Procedure Summary Online Version last updated 07/17/2015.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back- Lumbar and Thoracic Chapter, under MRIs.

Decision rationale: The patient was injured on 05/05/89 and presents with low back pain which radiates to the right lower extremity. The request is for a MRI of the lumbar spine. The utilization review rationale is that "information submitted does not clearly reflect that there has been a significant change in status or progression of symptoms or examination findings that demonstrate the need for repeat imaging at this time". There is no RFA provided and the patient is to remain off of work. The patient had a prior MRI of the lumbar spine in October 2013 which revealed a 3.5- 5.0 mm disc bulge at L2-S1. The patient underwent a lumbar laminectomy on 09/17/14 and there is no indication of any MRIs of the lumbar spine the patient may have had after his operation. MTUS/ ACOEM Guidelines, Chapter 12, Special Studies Section, page 303 states, "Unequivocal and equivocal objective findings that identified specific nerve compromise on neurological examination or sufficient evidence to warrant imaging in patient who did not respond well to retreatment and who could consider surgery an option. Neurological examination is less clear; however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study". ODG Guidelines, Low Back- Lumbar and Thoracic Chapter, under MRIs states that "MRIs are tests of choice for patients with prior back surgery, but for uncomplicated low back with radiculopathy, not recommended until at least 1 month of conservative care, sooner if severe or progressive neurologic deficit". ODG Guidelines, Low Back- Lumbar and Thoracic Chapter, under Flexion/extension imaging studies states: "Not recommended as a primary criteria for range of motion. An inclinometer is the preferred device for obtaining accurate, reproducible measurements, See Range of motion (ROM); Flexibility. For spinal instability, may be a criteria prior to fusion, for example in evaluating symptomatic spondylolisthesis when there is consideration for surgery." The patient has tenderness in the low back, sensory loss, myofascial tenderness, and a positive facet loading. He is diagnosed with lumbar degenerative disc disease and radiculopathy, facet joint pain, and lumbar laminectomy (9-17-14). The reason for the request is not provided. Given that the patient has not had a MRI of the lumbar spine after his surgery, the request appears reasonable and is in accordance with guidelines. The request is medically necessary.