

Case Number:	CM15-0168303		
Date Assigned:	09/09/2015	Date of Injury:	07/22/2005
Decision Date:	10/14/2015	UR Denial Date:	07/28/2015
Priority:	Standard	Application Received:	08/26/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 59-year-old female, who sustained an industrial injury on 7-22-2005. Diagnoses include lumbar radiculopathy status post fusion L4-S1 and healing cervical arthrodesis for pseudo arthrosis C3-T1, stable. Treatment to date has included multiple surgical interventions (lumbar fusion L4-S1, 2003, anterior-posterior cervical fusion in 2013, followed by cervical revision fusion in 2014), as well as conservative treatment including diagnostics, medications, injections, activity modification, psychiatric evaluation and treatment, and physical therapy. Per the Primary Treating Physician's Progress Report dated 7-13-2015, the injured worker presented for reevaluation. She reported increasing low back pain that radiates down the legs. The pain travels into the right buttock, on the right thigh, and into the knee and ankle. Objective findings of the neck included mild restriction of range of movement. There is no significant motor deficit in the upper extremities. There is no documentation of a physical examination of the lumbar spine. The evaluating provider as "a lumbar fusion that is solid at L4-5 and L5-S1 read X-rays of the lumbar spine. There is an intervertebral settling, particularly a L2-3 with large osteophytes." Per the Primary Treating Physician's Progress Report dated 3-02-2015, physical examination showed decreased range of motion of the lumbar spine. There was tightness with straight leg raise on both the right and left without any motor or sensory deficits. Magnetic resonance imaging (MRI) dated 2-09-2015 was documented by the provider as "fusion from L4-S1 with adjacent segment disease at L2-3, L3-4. There is disk desiccation and disk bulge creating mild to moderate bilateral neural foraminal narrowing at both levels." The plan of care included refill of medications and diagnostic testing, and authorization was requested on 7-

23-2015 for magnetic resonance imaging (MRI) of the lumbar spine without contrast. On 7-28-2015, Utilization Review denied the request for MRI without contrast, back.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI without contrast, Back, QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

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, MRIs (Magnetic resonance imaging).

Decision rationale: Per the ODG guidelines with regard to MRI of the lumbar spine: Recommended for indications below. MRI's are test of choice for patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy, not recommended until after 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 (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). (Bigos, 1999) (Mullin, 2000) (ACR, 2000) (AAN, 1994) (Aetna, 2004) (Airaksinen, 2006) (Chou, 2007) Magnetic resonance imaging has also become the mainstay in the evaluation of myelopathy. An important limitation of magnetic resonance imaging in the diagnosis of myelopathy is its high sensitivity. Indications for imaging: Magnetic resonance imaging: Thoracic spine trauma: with neurological deficit; Lumbar spine trauma: trauma, neurological deficit; Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit); Uncomplicated low back pain, suspicion of cancer, infection, other "red flags". Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. Uncomplicated low back pain, prior lumbar surgery; Uncomplicated low back pain, cauda equina syndrome; Myelopathy (neurological deficit related to the spinal cord), traumatic; Myelopathy, painful; Myelopathy, sudden onset; Myelopathy, stepwise progressive; Myelopathy, slowly progressive; Myelopathy, infectious disease patient; Myelopathy, oncology patient. Repeat MRI: When there is significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). Per the medical records, the injured worker had an MRI in 2013, which showed disc protrusion at L2-L3 and L3-L4. She had a prior fusion at L4-L5. She had an updated MRI on 2/9/15, which showed a fusion at L4-S1 and adjacent segment disease at L2-L3 and L3-L4 with disc desiccation, and disc bulges creating neural foraminal narrowing at both levels. On physical exam, she had mild antalgia to the left; she had a decreased range of motion of the lumbar spine. She had no motor or sensory deficits. Per the citation above, repeat MRI is only supported when there is significant change in symptoms and/or findings suggestive of significant pathology. Repeat MRI is not indicated. The request is not medically necessary.