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| Case Number: | CM15-0027806 | | |
| Date Assigned: | 02/20/2015 | Date of Injury: | 03/22/2011 |
| Decision Date: | 04/07/2015 | UR Denial Date: | 01/20/2015 |
| Priority: | Standard | Application Received: | 02/13/2015 |

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, Hawaii
 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 47 year old female who sustained an industrial injury on 03/22/2011. Diagnoses include complex regional pain syndrome, chronic lumbar strain/sprain, lumbago, and chronic left radiculopathy. Treatment to date has included medications, and recent functional capacity evaluation. A physician progress note dated 12/18/2014 documents the injured worker complains of chronic low back pain and pain radiating down the left leg, with associated numbness, tingling and weakness. She rates her pain at an average of 8 out of 10. Her activities of daily living are limited due to pain. She also reports head pain with bilateral shoulder radiation. Lumbar range of motion is diminished and there is tenderness over the lower L3-S1 paraspinal with spasms. There is slight weakness in the left anterior tibialis, extensor hallucis longus and gastrocnemius. He left calf is colder to touch that the right. The left calf is tender to palpation over the lateral and medial aspect. Treatment requested is for Magnetic Resonance Imaging without contrast of the lumbar spine. On 01/20/2015 Utilization Review non-certified the request for Magnetic Resonance Imaging without contrast of the lumbar spine and cited was Official Disability Guidelines, and California Medical Treatment Utilization Schedule (MTUS) - American College of Occupational and Environmental Medicine (ACOEM).

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Without Contrast 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); Repeat MRIs.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back, MRIs.

Decision rationale: The patient presents with pain affecting the low back with radiation down the left leg accompanied with numbness, tingling, and weakness. The current request is for MRI without contrast of the lumbar spine. The treating physician report dated 1/27/15 (73B) states, "During our last visit, we requested an MRI of her lumbar spine for increasing radicular complaints; however, this has been denied." A QME report dated 6/27/14 states, "Of concern are her positive MRI and NCV findings of disc protrusion with associated radiculopathy." The QME goes on to note that the lumbar MRI was dated 2/14/12. The MTUS guidelines do not address the current request. The ODG has the following regarding 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 (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation)." In this case, the patient has received a previous MRI of the lumbar spine and there is no evidence in the documents provided that suggests that the patient has had a significant change in symptoms. The ODG guidelines only recommend a repeat MRI if the patient is experiencing a significant change in symptoms that is corroborated by findings during examination. The current request does not satisfy the ODG guidelines as outlined in the "Low Back" chapter. Recommendation is for denial.