

Case Number:	CM15-0213184		
Date Assigned:	11/03/2015	Date of Injury:	04/16/2012
Decision Date:	12/15/2015	UR Denial Date:	10/13/2015
Priority:	Standard	Application Received:	10/29/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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 68 year old female, who sustained an industrial injury on 4-16-2012. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar radiculopathy. On 9-30-2015, the injured worker reported lumbar spine pain flare up with dull achy pain in the L4-L5 midline radiating down the right leg to the lateral malleolus. The Treating Physician's report dated 9-30-2015, noted the injured worker had received two lumbar epidural steroid injections (ESIs) with little benefit. The Physician noted a MRI of the lumbar spine from 6-18-2012 was noted to show moderate to severe spinal canal stenosis at L4-L5 secondary to degenerative disc and facet disease. The physical examination was noted to show tenderness and pain in the lumbar spine with normal range of motion (ROM), no bony tenderness, swelling, edema, or deformity. The injured worker was noted to have normal sensation and normal reflexes with no sensory deficits, normal muscle tone, normal straight leg raise, and normal gait. The treatment plan was noted to include an order for a MRI of the lumbar spine and continuation of the Tramadol. The injured worker's work status was noted to be modified work. The request for authorization was noted to have requested a MRI of the lumbar spine without contrast. The Utilization Review (UR) dated 10-13-2015, non-certified the request for a MRI of the lumbar spine without contrast.

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 without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment In Workers' Compensation, Chapter: Low Back-Lumbar and Thoracic (Acute and Chronic).

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-Lumbar & Thoracic (Acute & Chronic), MRIs (magnetic resonance imaging).

Decision rationale: The claimant sustained a work injury in April 2012 when, while working as a janitor, she had low back pain while lifting. An MRI of the lumbar spine in June 2012 showed findings of multilevel mild to moderate disc bulging and moderate facet arthritis with moderate to severe spinal canal stenosis at L4/5 and mild foraminal narrowing at L5/S1. She had two epidural injections with limited benefit. In June 2014 she was having bilateral paralumbar pain and ongoing pain radiating into the right leg. When seen in September 2015 she was having a flare-up of symptoms. She had midline pain radiating to the right leg which was increased with lifting and decreased with rest. Physical examination findings included lumbar tenderness and pain. There was normal range of motion. There was a normal neurological examination. Authorization was requested for an MRI scan of the lumbar spine. Guidelines indicate that a repeat MRI of the lumbar spine 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). In this case, there is no apparent significant change in symptoms or findings suggestive of significant new pathology as the same complaints and physical examination findings were recorded more than one year prior to this request. There are no neurological deficits. A flare-up of symptoms is referenced without described response to conservative treatments. For any of these reasons, a repeat MRI is not medically necessary.