

Case Number:	CM15-0040606		
Date Assigned:	03/10/2015	Date of Injury:	08/24/2000
Decision Date:	04/20/2015	UR Denial Date:	02/24/2015
Priority:	Standard	Application Received:	03/03/2015

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 58 year old male, who sustained a work/ industrial injury on 8/24/00. He has reported initial symptoms of low back and knee pain. The injured worker was diagnosed as having vertebral disc displacement without myelopathy. Treatments to date included medication, physical therapy, and surgery. Currently, the injured worker complains of recurrent pain in back and knee. The treating physician's report (PR-2) from 2/11/15 indicated there was a significant decrease in symptoms in the right knee following surgery but now with recurrence and also complaints of increased symptoms of lumbosacral after surgery due to altered gait. Examination noted right knee having crepitus and tenderness. The lumbar area was tender with spasm and having decreased range of motion. Diagnosis was displacement of intervertebral disc without myelopathy and internal derangement of knee. Treatment plan included a repeat of the Magnetic Resonance Imaging (MRI) of lumbar spine to rule out progression of stenosis since last Magnetic Resonance Imaging (MRI), repeat series of Synvisc injections to the right knee>postpone need for additional surgery, and return to review results of MRI and begin injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI (magnetic resonance imaging) 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), MRI (magnetic resonance imaging).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Lower back Chapter, MRIs.

Decision rationale: The patient presents with pain in his lower back and knee. The request is for MRI OF THE LUMBAR SPINE. The patient has had MRI of the lumbar spine on 05/12/08, showing a 4mm disc bulge at L4-5 with bilateral facet arthropathy and a 3mm central to the left disc bulge at L5-S1 with moderate left neural foraminal narrowing. Regarding repeat MRI study, ODG under Lower back Chapter, MRIs magnetic resonance imaging states "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, the treater has asked for an updated MRI to rule out progression of stenosis compared to the last MRI. The patient was doing well with the knee condition, but the symptoms have recently increased. The treater is concerned about progression of spinal stenosis but also seeking treatments for the knee. The requested updated MRI does not appear warranted based on the guidelines. There are no exam findings showing progression of the patient's stenosis symptoms, or neurogenic claudication. Presenting history does not show worsening stenosis. The patient's symptoms appear to be limited to the knee and the low back. No significant radicular symptoms are described. The request IS NOT medically necessary.