

Case Number:	CM15-0240406		
Date Assigned:	12/17/2015	Date of Injury:	09/07/2012
Decision Date:	01/22/2016	UR Denial Date:	11/24/2015
Priority:	Standard	Application Received:	12/09/2015

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:

This is a 41 year old male who sustained a work-related injury on 9-7-12. Medical record documentation revealed the injured worker had as surgical evaluation on 9-3-15 for evaluation of low back pain. He reported bilateral low back pain with radiation of pain down the back of his legs to his feet. He rated the pain 9 on a 10-point scale and noted the pain was burning-stinging and worsened with walking, standing and sitting. He reported that pain medications and muscle relaxants provided only marginal relief. He had weakness throughout his lower extremities and had 5-6 episodes of nocturnal incontinence each month. Previous therapy included steroid injection, epidurals and physical therapy. The injured worker was unable to work and could only ambulate with a cane for short distances due to pain and weakness. Objective findings included an antalgic gait on the right with use of a cane in the right hand. He was unable to heel and toe walk, squat or rise without assistance. He had 5-5 strength in the lower extremities and his sensation was intact through the L2-S1 dermatomes. Patellar and Achilles reflexes were 2+ bilaterally and he had negative Babinski and Clonus tests. A magnetic resonance imaging (MRI) of the lumbar spine on 11-17-15 revealed at L3-4, no disc bulge or focal protrusion, prominent fat posterior to the thecal sac, no foraminal narrowing and mildly hypertrophic facets; at L4-5, narrowing of the disc with desiccation, posterior bulging with encroachment on the thecal sac, mild narrowing of the foraminal bilateral and hypertrophic facets. A request for a magnetic resonance imaging (MRI) of the lumbar spine with sedation was received on 11-17-15. On 11-24-15, the Utilization Review physician determined a magnetic resonance imaging (MRI) of the lumbar spine with sedation was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro MRI of lumbar spine with sedation: 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-Lumbar & Thoracic (Acute & Chronic), MRIs (magnetic resonance imaging): Indications for imaging.

Decision rationale: The claimant sustained a work injury in September 2012 when he had low back pain while loading a truck. In April 2013, he underwent an L4/5 decompression. A post-operative MRI scan of the lumbar spine was done in July 2013. He was seen in an Emergency Room on 08/27/15. He was having back pain with leg cramping. He had undergone a caudal epidural injection one month before with little pain relief. He was having occasional urinary incontinence. He was having difficulty ambulating. An MRI of the cervical, thoracic, and lumbar spine was obtained. The lumbar spine MRI was compared with a previous MRI on 06/19/15 and was unchanged. The scan was degraded by motion artifact. He was seen for an initial evaluation by the requesting provider on 09/30/15. When seen in September 2015 he was having low back pain radiating into the legs and feet bilaterally. He was having 5-6 episodes of nocturnal incontinence each month. He was only able to ambulate with a cane for short distances due to pain and weakness. Physical examination findings included a body mass index of 33. He had an antalgic gait and was using a cane. There was normal bilateral lower extremity strength and sensation and reflexes were symmetrical. Lumbar x-rays were obtained and a prior MRI result was reviewed. Authorization was requested for MRI scans of the cervical, thoracic, and lumbar spine with contrast and sedation. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology such as tumor, infection, fracture, neuro-compression, or recurrent disc herniation. In this case, the claimant underwent MRI scans of the entire spine one month before this request and three months before in June 2015. When seen, there were no physical examination findings such as decreased strength or sensation in a myotomal or dermatomal pattern or asymmetric reflex response that supports a diagnosis of radiculopathy. The requested MRI of the lumbar spine is not medically necessary.