

Case Number:	CM14-0216951		
Date Assigned:	01/06/2015	Date of Injury:	12/20/1994
Decision Date:	03/06/2015	UR Denial Date:	12/19/2014
Priority:	Standard	Application Received:	12/29/2014

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, 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 48 year old male who sustained a work related injury December 20, 1994. A primary treating physician's progress report dated September 10, 2014, finds the injured worker presenting with increased radicular pain in the left lower extremity, difficulty walking, and changing positions. At that time the treatment plan included continuing Lyrica, Mobic and Zanaflex and a request for lumbar epidural injection which was non-certified according to a physician's letter dated November 5, 2014. According to a primary treating physician's progress report dated December 10, 2014, the injured worker presented with complaints of increased left leg pain and difficulty walking, changing position and getting onto the examining table. Physical examination of the lumbar spine reveals guarding with motion, muscle spasm, and positive straight leg raise to the left in a sitting as well as supine position. Straight leg raise is negative to the right in a sitting as well as supine position. Gait is antalgic. Sensation is decreased left and right L5 and S1. Diagnoses are documented as s/p posterior decompression and fusion L5-S1 1996 and central disc herniation at L3-4 with moderate foraminal stenosis. Treatment plan is documented as request for MRI scan of the lumbar spine. Work status is documented as permanent and stationary. There is no x-ray or past MRI reports present in the medical record. According to utilization review performed December 19, 2014, the request for Magnetic Resonance Imaging (MRI) of the Lumbar Spine with and without contrast is non-certified. Citing MTUS ACOEM Guidelines Summary of Recommendations Low Back Disorders, there is lack of medical documentation present in the medical record and no evidence of any progressive

neurological deficits or how the study would alter treatment. A peer to peer call was attempted but not completed successful with the requesting provider.

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 with and without contrast: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM www.acoempracguides.org/lowback

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Low Back Chapter, MRI

Decision rationale: Regarding the request for repeat lumbar MRI, ACOEM Practice Guidelines do not have specific guidelines on when a repeat study is warranted. In general, lumbar MRI is recommended when there are unequivocal objective findings that identify specific nerve compromise on the neurologic examination in patients who do not respond to treatment and would consider surgery an option. The Official Disability Guidelines state that repeat MRIs should be reserved for cases where a significant change on pathology has occurred. Within the documentation available for review, there is identification of significant change in pathology according to the requesting provider. In a progress note from date of service December 10, 2014, the requesting provider states that the patient not only experiences increased pain, but difficulty with day-to-day activities. The physical examination is notable for decrease in sensation in the L5 and S1 dermatomes and the patient is noted to have difficulty walking and changing positions. Although this physical examination is similar to the exam from date of service September 10, 2014, both examinations indicate neurologic dysfunction. Furthermore, in a patient with a history of posterior decompression and fusion at L5-S1 and with known disc herniation at L3-4, a repeat study would be worthwhile given that the client in function documented. This request is medically necessary.