

Case Number:	CM15-0116250		
Date Assigned:	06/26/2015	Date of Injury:	01/15/2013
Decision Date:	07/27/2015	UR Denial Date:	06/11/2015
Priority:	Standard	Application Received:	06/16/2015

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 53 year old female who sustained a work related injury January 15, 2013. Past history included L5-S1 bilateral medial facetectomy and foraminotomies, transforaminal lumbar interbody fusion with cage June, 2014, and hypertension. According to a primary treating physician's progress report, dated May 21, 2015, the injured worker presented with complaints of constant moderate to severe pain in the lumbar spine. She reports weakness into her right and left lower extremities, right greater. There were complaints of frequent moderate pain in the bilateral knees aggravated by standing and kneeling. Objective findings of the lumbar spine; plus three spasms and tenderness to the bilateral lumbar paraspinal muscles form L4-S1, multifidus and right piriformis muscle. Kemp's test and straight leg raise were positive bilaterally. The S1 dermatome was decreased on the left to light touch. There is mild swelling of the right knee. There was three plus spasm and tenderness to the bilateral anterior joint lines and popliteal fossa. Diagnoses are lumbar spondylosis with myelopathy; sciatica. Treatment included instruction/ education of home exercise program, prescribed medication, pending follow-up with pain management, and at issue, a retrospective request for authorization for a 3D MRI of the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective: 3D magnetic resonance imaging (MRI) of the lumbar spine (DOS: 6/4/2015):
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), Lumbar: MRI.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Special Studies and Diagnostic and Treatment Considerations Page(s): 303.

Decision rationale: Regarding the indications for imaging in case of back pain, MTUS guidelines stated: "Lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. However, it may be appropriate when the physician believes it would aid in patient management. Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures)". Furthermore, and according to MTUS guidelines, MRI is the test of choice for patients with prior back surgery, fracture or tumors that may require surgery. In this case, the patient has had an MRI and CT scan in March of 2015 (10 months after her lumbar surgery). There is no clear evidence of new lumbar nerve root compromise. There is no clear evidence of significant change in the patient signs or symptoms suggestive of new pathology. Therefore, the retrospective request for 3D magnetic resonance imaging (MRI) of the lumbar spine is not medically necessary.