

<b>Case Number:</b>	CM13-0026913		
<b>Date Assigned:</b>	09/03/2014	<b>Date of Injury:</b>	04/18/2007
<b>Decision Date:</b>	09/23/2014	<b>UR Denial Date:</b>	09/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/19/2013

### 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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

There were 69 pages provided for review. The request was for an outpatient repeat MRI of the lumbar spine. Per the records provided, the claimant was described as a 43-year-old female injured on April 18, 2007. Per a QME on October 3, 2008, the patient was not found to be a surgical candidate. She underwent a discogram and surgery was recommended. She underwent an anterior and posterior lumbar spine fusion of L5-S1 on January 22, 2010 and a left C7-T1 microscopic hemilaminectomy, medial facetectomy, and microdiscectomy on June 19, 2012. The patient is on modified duty and complains of pain in the low back and some stress incontinence from the bladder. This was said to be non-industrial and she is seeing an urologist. [REDACTED] opined that a lumbar fusion was not medically necessary and indicated that a simple microdiscectomy and disc excision was appropriate. The doctor noted she went on with surgery anyway, the patient now continues to be symptomatic with a higher degree of permanent disability per his opinion. There is now lucent screw based on the report they may need removal of hardware. They recommend a current MRI and flexion extension AP and lateral and oblique view x-rays of the lumbar spine. An EMG was also requested. The previous reviewer noted that without information in regards to the most recent MRI scan of the lumbar spine, and without evidence of clinical deterioration since the last MRI non certification was recommended. There was a note from November 7, 2013. She was lifting a helium tank out of a trunk and twisted her back with immediate low back pain. A discogram was performed and a panel QME felt she was not a surgical candidate. However she went on to surgery under a [REDACTED]. She returned to modified duty and she had increased symptoms. The January 2013 MRI showed a disc protrusion. She still has constant mid and low back pain. X-ray showed 360 lumbar arthrodesis with interference screws, a solid intravertebral graft at L5-S1 with screw cages. There is retrolisthesis of L4 and L5.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Repeat MRI for Lumbar Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, MRI.

**Decision rationale:** Under MTUS/ACOEM, although there is subjective information presented in regarding increasing pain, there are little accompanying physical signs. Even if the signs are of an equivocal nature, the MTUS note that electrodiagnostic confirmation generally comes first. They note '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.' The guides warn that indiscriminate imaging will result in false positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. I did not find electrodiagnostic studies. It can be said that ACOEM is intended for more acute injuries; therefore other evidence-based guides were also examined. The ODG guidelines note, in the Low Back Procedures section:- Lumbar spine trauma: trauma, neurological deficit- Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit)- Uncomplicated low back pain, suspicion of cancer, infection- Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. (For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383.) (Andersson, 2000)- Uncomplicated low back pain, prior lumbar surgery- Uncomplicated low back pain, cauda equina syndrome These criteria are also not met in this case. Moreover, with all of the metal hardware in place from past fusion, it would obscure the MRI with metallic artifact, making it a largely useless test. Therefore, the request is not medically necessary.