

Case Number:	CM13-0002741		
Date Assigned:	07/02/2014	Date of Injury:	06/06/2009
Decision Date:	07/31/2014	UR Denial Date:	07/15/2013
Priority:	Standard	Application Received:	07/23/2013

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:

The claimant was injured on 06/06/09. An MRI of the lumbar spine is under review. On 03/05/14, the patient saw [REDACTED] and he stated that he ordered an MRI and she was in to discuss the results. An MRI dated 02/10/14 showed continued multilevel degenerative joint and disc disease. There was a slight increase in foraminal stenosis bilaterally at L3-4 due to disc bulging and posterior element hypertrophy. Otherwise it was unchanged since 2009. She was independent potential candidate for epidural steroid injections. On 05/15/14, she was seen for follow-up. She still had occasional back pain radiating to her lower extremities, mostly in her thighs and lateral calf with prolonged walking. She was still off for getting decompression treatment and was taking medications. Physical examination was about the same. There were no neurologic changes. She was making slow progress. There was evidence of radicular irritation and possible compression on MRI. An interlaminar epidural steroid injection was recommended. She was also given a Boston back brace. The claimant saw [REDACTED] on 06/12/14. She was doing relatively well but had a recent traction session which caused an exacerbation of her pain radiating to her left hip. She noticed more and more pain radiating into her bilateral lower extremities which was a relatively new symptom. It was burning in nature and sometimes went into the calf and was worse with activity. She was still taking Mobic and Flexeril. She had bilateral lumbosacral paraspinal tenderness to palpation with restrictions in both flexion and extension. Neurological examination was unchanged but there was bilateral weakness in her dorsiflexion and EHL which was 4/5 and slightly worse than her last exam. A repeat MRI was recommended. She had reported some increased radiation of her pain into her left greater than right leg with some clinical weakness and an MRI was ordered on 08/14/13. The MRI was non-certified at that time. She was last seen in May and was being treated for low back pain with radiation to her lower extremities likely due to chronic degenerative joint and disc

disorder with some radicular pain. At her last visit she was continuing her chiropractic decompressive treatment and had about 10 sessions left. She felt it was offering her relief and improvement in her symptoms. She denied any new symptoms, new weakness, numbness, or changes in bowel or bladder. She was in no apparent distress. Exam showed paraspinal tenderness to palpation with restrictions in flexion and extension due to pain. Neurological exam was unchanged. One more month off work was recommended. After that she would try to go back.

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: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: The history and documentation do not objectively support the request for a repeat MRI in the absence of clear evidence of new or progressive neurologic deficits and/or failure of a reasonable course of conservative treatment for any increase or change in symptoms or findings. The ACOEM Guidelines state 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). Electromyography (EMG), including H reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. The specific indication for this study has not been clearly described and none can be ascertained from the records. The claimant reported some increased symptoms from chiropractic treatment but there is no evidence of significant new or progressive focal neurologic deficits that require a repeat imaging study. There is no indication that a course of treatment was recommended and completed or attempted and the claimant failed to improve. No EMG was reported. The medical necessity of this study has not been demonstrated.