Case Number:	CM13-0023863		
Date Assigned:	11/15/2013	**Date of Injury:**	06/17/1996
Decision Date:	01/29/2014	**UR Denial Date:**	09/05/2013
Priority:	Standard	**Application Received:**	09/12/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management, has a subspecialty in Disability Evaluation 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 physician 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 patient is a retired 60-year-old female who sustained injuries on the following dates: (a) June 17, 1996, (b) April 3, 1998, and (c) cumulative trauma from 1987 until the present. She is diagnosed with (a) Lumbar spine sprain/strain with right lower extremity radiculopathy and 1.5 mm disc bulging at Ll-L3, 3mm disc protrusion at L4-5; (b) Facet osteoarthritis 13-5 with associated stenosis L3-4; and (c) Grade 1 anterolisthesis L3 on L4 as per MRI scan dated October 2011. On May 8, 2013, she reported that her lumbar spine epidural steroid injections administered on March 19, 2013, with [redacted] helped decrease symptoms about 65% and was still providing some relief. Examination of the lumbar spine revealed tenderness over the paraspinals with noted muscle guarding. Range of motion was limited in all planes and straight leg raising test was positive on the right. Aquatic therapy twice a week for four weeks was requested to decrease pain and increase motion. Consideration for discharge will be deemed on her next visit. On her subsequent visit on August 5, 2013, the patient stated that her pain levels have increased over the last three weeks. She noted that standing for five minutes increased the pain and also noted increased pain in transitioning from sitting to standing. She already had undergone four epidural steroid injections without lasting relief and expressed to consider surgical options. Examination of the lumbar spine revealed tenderness over the paraspinals with noted muscle guarding. Range of motion was still limited. Straight leg raising test was positive on the right lower extremity and radiates to the knee. Sensation was decreased with lumbar spine dermatomes. She was prescribed Tylenol #4 to be taken twice a day. A request for an updated MRI scan to the lumbar spine was made. Her last MRI scan was two years ago. This request was also based on the patient's consideration about undergoing surgery due to unusual radicular symptoms and increased difficulty

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar spine MRI: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation ODG for Low Back regardings MRIs

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 178.

Decision rationale: According to the ACOEM Guidelines, physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. Reliance on imaging studies alone to evaluate the source of neck or upper back symptoms carries a significant risk of diagnostic confusion (false-positive test results) because it is possible to identify a finding that was present before symptoms began and, therefore, has no temporal association with the symptoms. This patient had an earlier EMG and NCV ordered by [redacted] that was normal. A repeat EMG and NCV would have been appropriate prior to requesting a repeat MRI scan of the lumbar spine. Therefore, the request for a repeat MRI scan of the lumbar spine is not medically necessary at this time.