

<b>Case Number:</b>	CM13-0037953		
<b>Date Assigned:</b>	02/05/2014	<b>Date of Injury:</b>	06/15/2010
<b>Decision Date:</b>	05/21/2014	<b>UR Denial Date:</b>	09/03/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2013

### 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 Family Medicine, and is licensed to practice in New Jersey. 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 worker is a 36-year-old who was injured on June 15, 2010 while working as a drywall installer. Treatment for thoracic and lumbar pain related to this injury began soon afterwards including oral medications, physical therapy, chiropractor manipulations, acupuncture therapy, work restrictions, and epidural injections. An MRI of the lumbar spine was performed on October 18, 2010 revealing disc bulges at L3-L4, L4-L5, and another at L5-S1. Repeat lumbar MRIs from March 14, 2012 and May 14, 2013 each showed essentially the same pathology, including facet hypertrophy and bilateral neuroforaminal narrowing. Based on the progress note from 8/20/13, the worker was seen by his treating physician reporting worsening of his back pain over the prior few months. The worker was told by his chiropractor that disc protrusions may have increased in size causing his worsening pain, and the worker asked his treating physician for an MRI of his thoracic and lumbar spine to evaluate for this. Also during the visit on August 20, 2013, his examination revealed a positive seated straight leg raise test and was recommended that the worker get another epidural injection since he had responded to this treatment in the past.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI OF LUMBAR SPINE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 296-310. Decision based on Non-MTUS Citation Official Disability Guidelines.

**Decision rationale:** The Low Back Complaints Chapter of the ACOEM Practice Guidelines for diagnostic considerations related to lower back pain or injury require that for MRI to be warranted there needs to be unequivocal objective clinical findings that identify specific nerve compromise on the neurological examination (such as sciatica) in situations where red flag diagnoses (cauda equina, infection, fracture, tumor, dissecting/ruptured aneurysm, etc.) are being considered, and only in those patients who would consider surgery as an option. In some situations where the patient has had prior surgery on the back, MRI may also be considered. The Low Back Complaints Chapter of the ACOEM Practice Guidelines also states that if the straight-leg-raising test on examination is positive (if done correctly) it can be helpful at identifying irritation of lumbar nerve roots, but is subjective and can be confusing when the patient is having generalized pain that is increased by raising the leg. The Official Disability Guidelines (ODG) state that for uncomplicated low back pain with radiculopathy MRI is not recommended until after at least one month of conservative therapy and sooner if severe or progressive neurologic deficit is present. The ODG also states that repeat MRI should not be routinely recommended, and should only be reserved for significant changes in symptoms and/or findings suggestive of significant pathology. The worker in this case according to the records provided did not have any reported symptoms of neurological compromise that was worse than prior times MRI was used to evaluate, and only a positive straight leg raise was found on examination on August 20, 2013 with his treating physician.