

Case Number:	CM13-0040254		
Date Assigned:	12/20/2013	Date of Injury:	07/06/2000
Decision Date:	02/19/2014	UR Denial Date:	10/16/2013
Priority:	Standard	Application Received:	10/29/2013

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 Physical Medicine & Rehabilitation 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 49-year-old male who reported an injury on 07/06/2000. The mechanism of injury was lifting and twisting. The patient's conservative care included physical therapy, chiropractic, massage, epidural steroid injections, facet joint injections, medications, and activity modification. The patient is also known to have had an MRI of the lumbar spine that was performed on an unknown date, revealing a herniated nucleus pulposus at L4-5; another MRI performed on 04/10/2013 reported 6 mm disc bulge at L4-5 with suspected impingement of the right L5 nerve root as well as perineural cysts at L1-2 and L2-3. The patient's EMG/NCS performed on 12/28/2012, revealed right active L5 denervation, but no evidence of peripheral neuropathy was noted in the bilateral lower extremities. A complete list of the patient's current medications was not included; however, it is noted that he takes ibuprofen 600 mg twice a day with some relief. The patient's current diagnoses included lumbar spine strain/sprain syndrome, multilevel discogenic disease with right lower extremity radiculopathy, flare up of lumbar radiculopathy, lumbar spine disc protrusion at L4-5 with radiculopathy, and status post lumbar spine microdiscectomy and foraminotomy on 06/26/2013. There were no operative or procedure notes, or discussion in the clinical records regarding the surgical procedure in 06/2013. No other clinical information was submitted for review.

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: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back Chapter, MRI

Decision rationale: The patient is a 49-year-old male who reported an injury on 07/06/2000. The mechanism of injury was lifting and twisting. The patient's conservative care included physical therapy, chiropractic, massage, epidural steroid injections, facet joint injections, medications, and activity modification. The patient is also known to have had an MRI of the lumbar spine that was performed on an unknown date, revealing a herniated nucleus pulposus at L4-5; another MRI performed on 04/10/2013 reported 6 mm disc bulge at L4-5 with suspected impingement of the right L5 nerve root as well as perineural cysts at L1-2 and L2-3. The patient's EMG/NCS performed on 12/28/2012, revealed right active L5 denervation, but no evidence of peripheral neuropathy was noted in the bilateral lower extremities. A complete list of the patient's current medications was not included; however, it is noted that he takes ibuprofen 600 mg twice a day with some relief. The patient's current diagnoses included lumbar spine strain/sprain syndrome, multilevel discogenic disease with right lower extremity radiculopathy, flare up of lumbar radiculopathy, lumbar spine disc protrusion at L4-5 with radiculopathy, and status post lumbar spine microdiscectomy and foraminotomy on 06/26/2013. There were no operative or procedure notes, or discussion in the clinical records regarding the surgical procedure in 06/2013. No other clinical information was submitted for review.