

<b>Case Number:</b>	CM13-0063919		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	10/22/2007
<b>Decision Date:</b>	03/27/2014	<b>UR Denial Date:</b>	11/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/10/2013

### 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 Internal 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 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 50 year old male who injured his back on 10/22/2007. Prior treatment history has included Norco, Exalgo, Neurontin, Nortriptyline, TENS unit, physical therapy and referral to Pain specialist. Diagnostic studies reviewed include MRI performed 10/22/2012 revealed broad-based disc protrusion at L5-S1 measuring 1 mm; facet hypertrophy at L3-L4 and L4-L5. These results were documented in a note by [REDACTED] in April 2013. Hard copies of MRI results were not provided with records. NCS/EMG demonstrated findings consistent with carpal tunnel syndrome in wrists bilaterally. There was no evidence of cervical radiculopathy. In a note on 04/26/2013, [REDACTED], pain specialist, noted muscle girth is symmetric in all limbs. Lumbar ranges of motion were restricted by pain. Discogenic provocative maneuvers, including pelvic rock, were negative bilaterally; sacroiliac provocative maneuvers, including SI compression, iliac gapping, Yeoman's and shear were negative bilaterally. Nerve root tension signs were negative bilaterally. Muscle stretch reflexes were 1 and symmetric bilaterally in all limbs. Muscle strength was 5/5 in all limbs. Sensation was intact to light touch, pinprick, proprioception, and vibration in all limbs. In July 2013, patient underwent diagnostic six level lumbar nerve blocks which resulted in a 70% reduction in bilateral lower back pain. This is a positive test for lumbar facet joint syndrome. Orthopedic follow-up noted dated 10/30/2013 documented the patient to have complaints of still having low back pain and bilateral lower extremity pain. Objective findings on exam include mild weakness in anterior tibialis bilaterally and a lot of pain in his feet. [REDACTED] notes that he reviewed MRI's of the patient's lumbar spine from 2011 and 2012, but nothing was found in his back that would be commensurate for the nerve pain that he is having going down his legs. A new MRI scan was requested. There was discussion of referring patient to Neurology for nerve conduction studies of his lower extremities. [REDACTED] was considering doing a spinal cord stimulator. More recently, in a

report dated 01/03/2014, pain specialist [REDACTED] evaluated the patient for a follow up appointment. On exam, he documented tenderness upon palpation of the thoracic and lumbar paraspinal muscles. Lumbar ranges of motion were restricted by pain in all directions. Lumbar discogenic provocative maneuvers were positive. Sacroiliac provocative maneuvers were positive bilaterally. Patrick's maneuver was positive bilaterally. Nerve root tension signs were negative bilaterally. Muscle stretch reflexes were 1 and symmetric bilaterally in all limbs. Muscle strength was 5/5 in all limbs. This was the same exam since 09/05/2013. The patient has failed physical therapy, NSAIDs, and conservative treatments.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**The request for MRI of the 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 rationale:** MRI of the lumbar spine is indicated if there is unequivocal objective evidence of specific nerve compromise on exam. The patient has been complaining of chronic low back pain with radiation to his lower extremities and associated lower extremity numbness for years. There are discrepancies in the neurologic exams documented by the patient's Pain specialist, [REDACTED], and spine surgeon, [REDACTED]. While [REDACTED] notes a normal lower extremity neurologic exam and feels that the pain is a result of lumbar facet arthropathy after a positive diagnostic multilevel lumbar nerve block. [REDACTED] documents mild weakness in the anterior tibialis bilaterally and diminished sensation in feet bilaterally. Per the referenced guidelines, when neurologic examination is less clear, further physiologic evidence of nerve function, such as nerve conduction studies and/or (EMG) Electromyography, should be obtained before imaging. Ordering imaging such as an MRI before this step can result in false positive results and potentially unnecessary surgery. Thus, MRI of the spine is not certified.