

<b>Case Number:</b>	CM14-0015294		
<b>Date Assigned:</b>	02/28/2014	<b>Date of Injury:</b>	01/22/2009
<b>Decision Date:</b>	06/27/2014	<b>UR Denial Date:</b>	01/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/06/2014

### 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 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 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 patient is a 46 year old female who sustained an industrial injury on 01/22/2009. The mechanism of injury is unknown. Prior treatment history has included synovacin-glucosamine sulfate 500 mg, nabumetone-relafen 500 mg, and pantopazole-protonix 20 mg; and LESI. The patient underwent a medial branch block injection on 09/24/2013. Visit note dated 01/27/2014 states the patient presents for follow-up of low back pain. She is status post medial branch injection on 09/24/2013 without much benefit. She notes that for the past 2 weeks, she has been experiencing increased pain. She reports her pain as 7-8/10 on the VAS scale without medications. She notes that her pain is located in her bilateral low back without any radiation of pain or radicular symptoms into her bilateral lower extremities. She denies bowel or bladder incontinence or saddle anesthesia. She notes that with the LESI, she gets over 70% pain relief that lasts for about 9 months. The patient is taking synovacin-glucosamine sulfate 500 mg, pantopazole-protonix 20 mg and etodolac Er 400 mg. On exam, her gait is normal and there is normal lordosis with no scoliotic deformity. Deep tendon reflexes are symmetrical bilaterally to the patellar and Achilles. There is no clonus sign bilaterally. Lumbar extension is measured to be 0 degrees; lumbar flexion is measured to be 20 degrees. Left lateral bending is measured to be 10 degrees and right lateral bending is measured to be 15 degrees. Sensation is intact to light touch and pinprick bilaterally to the lower extremities. Straight leg raise is positive on the left. There is no spasm or guarding noted. Dorsiflexion strength is 4/5 on the left extensor hallucis longus motor strength is 4/5 on the left; hip extension motor strength is 4/5 on the left; left hip flexion motor strength is 4/5; left knee extension motor strength is 4/5; left knee flexion motor strength is 4/5; and left plantarflexion strength is 4/5 on the left. The patient is diagnosed with lumbar disc displacement without myelopathy, sciatica, and sacrum disorders.

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

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

### **MAGNETIC RESONANCE IMAGING (MRI) OF THE LUMBAR SPINE: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** As per CA MTUS guidelines, unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. In this case, there is no evidence of nerve root impingement, such as radiating pain in a dermatomal distribution, sensory deficits or focal motor weakness. There are no neurological abnormalities such as saddle anesthesia or incontinence to warrant cervical MRI. There is no evidence of any red flag signs. No surgical intervention is being contemplated at this time. Thus, the request for MRI of the cervical spine is not medically necessary and is non-certified.