

Case Number:	CM14-0016233		
Date Assigned:	04/11/2014	Date of Injury:	07/19/2011
Decision Date:	05/29/2014	UR Denial Date:	01/31/2014
Priority:	Standard	Application Received:	02/10/2014

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 47 year-old who sustained an injury on July 19, 2011 while employed [REDACTED]. The report dated January 7, 2014 from the provider noted patient with complaints of severe low back and leg pain. Exam showed stiff gait; antalgic; decreased lumbar range of motion limited by pain; not motor, sensory or deep tendon reflexes identified on examining report. A report dated February 25, 2014 from the provider noted that the patient had complaints of constant low back pain with intermittent cramping to legs rated at 8/10. The patients medications includes Prilosec, Zanaflex, and Tramadol. Physical exam revealed a restricted lumbar range of motion secondary to pain. Diagnoses included lumbosacral intervertebral disc degeneration and displacement without myelopathy; spondylosis; chronic pain syndrome; GERD and constipation. An MRI of the lumbar spine on January 17, 2012 showed L5-S1 anterolisthesis with possible spondylosis associated with disc bulging. An MRI of the lumbar spine was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI W/O CONTRAST 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 ODG.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 303-304.

Decision rationale: According to the ACOEM Treatment Guidelines emergence of a red flag; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery; clarification of the anatomy prior to an invasive procedure are the criteria for ordering imaging studies. Physiologic evidence may be in the form of definitive neurologic findings on physical examination and electrodiagnostic studies. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. A review of submitted medical reports have not adequately demonstrated the indication for MRI of the Lumbar spine nor document any specific clinical findings to support this imaging study as the patient has intact neurological exam without deficits throughout bilateral lower extremities nor is there any acute flare-up or new injury to indicate for repeat study. When the neurologic examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Therefore, the request for an MRI of the Lumbar Spine, without contrast, is not medically necessary and appropriate.