MAXIMUS Federal Services

Case Number:	CM14-0017355		
Date Assigned:	04/14/2014	Date of Injury:	05/15/2013
Decision Date:	05/29/2014	UR Denial Date:	01/29/2014
Priority:	Standard	Application Received:	02/11/2014

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 and Rehabilitation has a subspecialty in Pain Management 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 35 year old with an injury date on 5/15/13. Based on the 1/17/14 progress report provided by [redacted], the diagnoses are: 1. sub-acute traumatic moderate repetitive lumbar spine sprain/strain radiating to both lower extremities; R/O herniated disc 2. sub-acute traumatic moderate repetitive bilateral knee sprain/strain; R/O ligamentous injury 3. anxiety/depression/stress with associated sexual dysfunction 4. nightly sleep disturbances The 12/27/13 report showed an epidural steroid lower back injection gave patient temporary relief for 5 days, and then caused headaches and an unpleasant odor spreading from lower back. On 1/1/14, patient stated medications gave temporary relief and improved ability to sleep. The 1/16/14 report by [redacted] states the patient was involved in a motor vehicle accident on 6/28/13, where patient was rear-ended, taken to the emergency room, and received an injection to the low back with some relief. The patient had an MRI of lumbar spine on 8/6/13 that showed significant facet joint arthropathy, a small 2-mm AP diameter central disk protrusion at L-5-S1 with reduction in height and signal, and L5-S1 degenerative disk disease with small central disk profusion, perhaps 2mm. [redacted] is requesting another set of MRI's for the patient's lumbar spine. The utilization review determination being challenged is dated 1/29/14. [redacted] is the requesting provider, and he provided treatment reports from 9/18/13 to 1/17/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI LUMBAR: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines http://www.odg-twc.com/odgtwc/low_back.htm#Protocols. Page(s): 303.

Decision rationale: According to 9/18/13 progress report by [redacted], this patient presents with "burning, radicular low back pain and muslce spasms, 7-9/10, radiating into the coccyx, both buttocks and in the bottom of the feet, associated with numbness and tingling of the bilateral lower extremities, constant, moderate to severe." The request is for an updated MRI of the patient's lumbar. The patient had a set of MRI's from 8/6/13. In reference to specialized studies, ACOEM guidelines state: "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery." For uncomplicated low-back pain, ODG guidelines require documentation of radiculopathy, not responding to conservative care, prior surgery or caudal equine. In this case, the patient has had an MRI on 8/6/13 and the treater does not explain why another set is required. There is no documentation of a new injury, significant deterioration of neurologic findings, and no red flags. No surgical planning is noted either. The request for the MRI is not medically necessary.