MAXIMUS Federal Services

| Case Number: | CM14-0150313 | | |
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| Date Assigned: | 09/18/2014 | Date of Injury: | 01/12/2010 |
| Decision Date: | 10/20/2014 | UR Denial Date: | 09/08/2014 |
| Priority: | Standard | Application Received: | 09/15/2014 |

## 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 Occupational 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 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 claimant injured his low back on 01/12/10 when he stepped into a hole at night and his foot dropped approximately 18 inches. He has persistent low back pain. A repeat MRI of the lumbar spine is under review. The diagnosis has been lumbar sprain/strain. An MRI dated 02/12/14 revealed no disc herniations. There was moderate left and mild right facet arthrosis at L5-S1 only. He had a PT reevaluation on 05/21/14. He had continued complaints of constant achy pain in his low back. It did not increase while moving. He had pain with sitting. Range of motion was decreased. He had negative neurovascular testing in the lower extremities with mildly decreased hip abduction. There were no focal neurologic deficits noted on 06/18/14. He was status post lumbar medial branch neurotomy bilaterally at L4, L5, and L6 on 06/03/14. PT helped his strength but not the pain. He was evaluated on 07/29/14 for low back pain. He had bilateral L5 and L6 medial branch blocks which helped but he did not respond to radiofrequency ablation. PT for 12 sessions and acupuncture for 6 sessions did not help. He was status post coccygeal ligament injection on 07/21/14 with 4 hours of relief but the pain returned to baseline. He had bilateral 4/10 axial back pain that was dull and better with rest and medication and worse with all other physical activity. He could root rise from a sitting seated position without difficulty. His gait was nonantalgic. He had severe pain over the coccyx and sacrococcygeal ligament and improved tenderness over the musculature of the low back. He had pain on extension and extension rotation. Facet palpation was positive bilaterally. Neurosensory exam was nonfocal. He had full strength. His medications were continued. An MRI showed no stenosis. He was referred to Ortho Spine. On 08/25/14, the claimant was evaluated and he complained of low back pain with numbness and tingling in the back of his left leg into the hamstrings which was intermittent. He has had acupuncture, chiropractic, and PT without resolution of symptoms and had 3 spinal injections including nerve blocks without relief. He

reported 80% of his pain was in his low back and 20% down his left leg. His low back pain was 8/10 in severity and left leg pain 3/10. He had been on light duty for about 9 months after the injury but was currently not working. Physical examination revealed a nonantalgic gait. He could heel and toe walk without difficulty. There was tenderness of his low back and more pain upon lumbar flexion. He had decreased range of motion upon flexion. Straight leg raise was positive for low back pain with the leg elevated to 60 from supine but no leg pain. He had full strength and normal sensation and reflexes. The provider stated in the summary that he had chronic persistent low back pain despite treatment. He has had 3 spinal injections including nerve blocks. He had a previous MRI at the beginning of this year but since then his symptoms progressively worsened. He had equivocal weakness in the left leg at the tibialis anterior and gastrocsoleus as well as the quadriceps. This was rated 4+/5. He had paresthesias and dysesthesias and tension signs in the left leg. Repeat MRI was recommended. He remained on medications. He was advised on continuing his home exercises. Of note, the neurologic examination and the findings in the discussion/plan are not consistent with each other.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI lumbar spine without contrast:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic), updated 08/22/2014

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back, MRI

**Decision rationale:** The history and documentation do not objectively support the request for a repeat MRI in the absence of clear evidence of new or progressive neurologic deficits and/or failure of a reasonable course of conservative treatment. The MTUS state "recommend CT or MRI when cauda equina, tumor, infection, or fracture are strongly suspected and plain film radiographs are negative (C); MRI test of choice for patients with prior back surgery (D)." The ODG state "repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g. tumor, infection, fracture, neurocompression, recurrent disc herniation). The claimant's physical examination findings on 08/25/14 are described as unremarkable but the provider indicated that he had neurologic deficits and a new study was ordered. This discrepancy is not explained in the records. The specific indication for a repeat study, including a new injury, new symptoms, new focal neurologic deficits, has not been clearly described and none can be ascertained from the records. The medical necessity of this study has not been demonstrated and a clarification was not obtained. Therefore, this request is not medically necessary.