

<b>Case Number:</b>	CM14-0167328		
<b>Date Assigned:</b>	10/14/2014	<b>Date of Injury:</b>	01/07/2003
<b>Decision Date:</b>	11/17/2014	<b>UR Denial Date:</b>	09/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/10/2014

### 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 Family 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:

This is a 59 year old female patient who sustained a work related injury on 1/7/03. Patient sustained the injury when the arm of the chair on which she was seated broke causing her to fall. The current diagnoses include lumbar spinal stenosis and low back pain per the doctor's note dated 6/25/14, patient has complaints of ongoing and progressive pain in her leg. Physical examination revealed some mild weakness of the left quadriceps, intact sensation in the lower extremities, good strength of dorsiflexion of foot and great toe and diminished left knee jerk. The doctor's note dated 1/30/14 revealed she has regained strength in her left leg, she was able to walk 2 miles on the treadmill, pain radiating down her leg in the distribution of the L4 nerve. On examination she was able to walk on her heels and toes, sensation was intact in both lower extremities and normal reflexes. The medication lists include Hydrocodone, Norco, Gabapentin, Soma, Insulin, Naprosyn, pravastatin, Chlorothiazide and Lisinopril. The diagnostic history include CT Abdomen and Pelvis on 8/6/2013; CT lumbar spine on 7/11/2012, 1/28/2011, and 2/6/2008; Myelogram lumbar spine on 2/19/2011; lumbar myelography 2/24/2011; Lumbar Spine X-ray on 11/12/2009; MRI of Lumbar Spine without Contrast on 2/10/2009, venous Doppler study of the left lower extremity on 6/30/14 with normal findings; X-ray of the low back on 6/25/14 that revealed elevation of the left hemipelvis indicating either lengthening of the left leg or shortening of the right and interval decrease in the joint space of the femoral acetabular joint which was normal; CT scan of the lumbar region on 6/19/14 that revealed severe collapse of the L3-4 disc with erosive arthritis in the facet joints and cyst formation in the disc and facet joints, MRI of the lumbar spine on 02/10/09 concluding degenerative changes at L3-4 with mild central canal narrowing, facet arthropathy with possible mass effect ontransiting left S1 root with mild to moderate canal narrowing, minimal L4-5 spondylolisthesis and bilateral L5-S1 facet arthropathy with metallic artifact within disc space; MRI scan taken post-operatively that

revealed a recurrent L5-S1 disc protrusion and evidence of a previous laminotomy, left side and EMG/NCV on 10/29/10. The past medical history includes Type 2 diabetes mellitus, Neuropathy, carpal tunnel syndrome, Morbid obesity, Hypertension, Left ventricular hypertrophy, Aortic stenosis. Patient had an echocardiogram in 04/2013, that revealed aortic stenosis, hypertrophy in the left ventricle with aortic stenosis with a 34 mm gradient across the valve. A dilated left atrium with mild mitral insufficiency and mild pulmonary hypertension. She has had hand cellulitis on the right ulnar palm and she was treated with incision and drainage. The patient's surgical history includes three back surgeries; anterior L5-S1 discectomy with intervertebral disc prosthesis on 1/20/2006; L4-5 fusion, L4-5 bilateral laminectomy and decompression of dural sac, on 01/22/2010. The patient's other surgical history includes open carpal tunnel release, right, on 4/24/14, Cholecystectomy, appendectomy, ventral hernia repair in 2006 and right knee arthroscopic surgery, and breast reduction in 2002. A report dated 08/09/04, revealed a permanent lifting restriction of 5 pounds, at loss for changing a position. The patient has received an unspecified number of physical therapy visits for this injury. The patient has used a knee brace and a cane for this injury in the past.

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

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

**MRI of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers' Comp., online Edition Chapter: Low Back (updated 10/28/14) MRIs (magnetic resonance imaging)

**Decision rationale:** Per the ACOEM low back guidelines cited below "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. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures)." ACOEM/MTUS guideline does not address a repeat MRI. Hence ODG is used. Per ODG low back guidelines cited below, "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 patient has had CT scan of the lumbar region on 6/19/14 that revealed severe collapse of the L3-4 disc with erosive arthritis in the facet joints and cyst formation in the disc and facet joints, MRI of the lumbar spine on 02/10/09 concluding degenerative changes at L3-4 with mild central canal narrowing, facet arthropathy with possible mass effect on transiting left S1 root with mild to moderate canal narrowing, minimal L4-5

spondylolisthesis and bilateral L5-S1 facet arthropathy with metallic artifact within disc space; MRI scan taken post-operatively that revealed a recurrent L5-S1 disc protrusion and evidence of a previous laminotomy. Any significant changes in objective physical examination findings since the last study, which would require a repeat study, were not specified in the records provided. Per the doctor's note dated 6/25/14, physical examination revealed intact sensation in the lower extremities, good strength of dorsiflexion of foot and great toe. The doctor's note dated 1/30/14 revealed she has regained strength in her left leg, she was able to walk 2 miles on the treadmill, and on examination she was able to walk on her heels and toes, sensation was intact in both lower extremities and normal reflexes. Patient did not have any evidence of severe or progressive neurologic deficits that are specified in the records provided. Any finding indicating red flag pathologies were not specified in the records provided. The history or physical exam findings did not indicate pathology including cancer, infection, or other red flags. As per records provided patient has received an unspecified number of physical therapy visits for this injury till date. A detailed response to complete course of conservative therapy including physical therapy visits was not specified in the records provided. Previous physical therapy visit notes were not specified in the records provided. A plan for an invasive procedure of the lumbar spine was not specified in the records provided. The medical necessity of the MRI of the lumbar spine is not fully established for this patient.