

Case Number:	CM14-0172443		
Date Assigned:	10/23/2014	Date of Injury:	09/02/2008
Decision Date:	11/21/2014	UR Denial Date:	09/18/2014
Priority:	Standard	Application Received:	10/17/2014

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 injured worker is a 62-year-old male who reported an injury on 09/02/2008. The mechanism of injury was not provided. The injured worker's diagnoses included lumbar disc disease, lumbar facet syndrome, and left piriformis syndrome. The injured worker's past treatments included medications, epidural steroid injection, home exercises, and bracing. The injured worker's diagnostic testing included an official MRI of the lumbar spine, performed on 03/18/2014, which indicated 2 mm disc bulge at L5-S1 with mild foraminal narrowing, degenerative disc disease at L4-5 with a prominent Schmorl's node at the inferior endplate of L4, and a 1 to 2 mm left paracentral posterior osteophyte at L1-2. The injured worker's surgical history included transforaminal epidural steroid injection to L5-S1, performed on 07/03/2014. On the clinical note dated 09/03/2014, the injured worker complained of low back pain that radiated numbness and tingling to the left foot. The injured worker rated his pain 5/10 to 6/10. The injured worker had tenderness to palpation over the bilateral paravertebral musculature, lumbosacral junction, and left sciatic notch. The injured worker had a straight leg raise test that was positive on the left, Kemp's tests positive bilaterally, and range of motion to the lumbar spine that was decreased in all planes. The injured worker had decreased sensation along the left L5 and S1 dermatomal distribution. The injured worker's medications included Sonata 10 mg at bedtime. The request was for an MRI of the lumbar spine. The rationale for the request was due to reported conditions that had worsened since the last diagnostic study. The Request for Authorization form was submitted for review on 08/06/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

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

Decision rationale: The request for MRI of the lumbar spine is not medically necessary. The injured worker is diagnosed with lumbar disc disease, lumbar facet syndrome, and left piriformis syndrome. The California MTUS/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. Indiscriminate imaging will result in false positive findings such as disc 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 consult the selection of an imaging test to define a potential cause. Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion because of the possibility of identifying a finding that was present before the symptoms began and therefore has no temporal association with the symptoms. The injured worker is complaining of back pain that radiates numbness and tingling to the left foot. The medical records indicate the injured worker had a positive straight leg raise test on the left that caused numbness and tingling along the left L5-S1 nerve root distribution. The MRI that was performed on 03/18/2014 indicated a 2 mm disc bulge with mild facet hypertrophy, and intervertebral neural foraminal narrowing at the L5-S1. The medical records lack indication of a significant change in symptoms or findings which indicate significant pathology to warrant an additional MRI. As such, the request for MRI of the lumbar spine is not medically necessary.