

Case Number:	CM14-0081994		
Date Assigned:	07/18/2014	Date of Injury:	01/25/2000
Decision Date:	08/26/2014	UR Denial Date:	05/05/2014
Priority:	Standard	Application Received:	06/03/2014

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 New Jersey. 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 worker is a 51 year old male who was injured on 1/25/2000 while pushing a wheelbarrow. He later was diagnosed with lumbar radiculopathy and chronic pain syndrome. He was treated with physical therapy, psychological therapy, TENS unit, medications, and surgery (lumbar laminectomy, 2002). The most recent lumbar MRI from 10/10/12 showed laminectomy defects at L1-2, L2-3, L3-4, and L4-5, L1-2 paracentral disc protrusion that abuts the thecal sac producing bilateral neuroforaminal narrowing and posterior annular tear, L2-3 disc bulge with left paracentral and foraminal disc protrusion compressing left L2 nerve root and left more than right neural foraminal narrowing, L3-4 disc protrusion and facet hypertrophy with bilateral neural foraminal narrowing and posterior annular tear, L4-L5 disc protrusion and facet hypertrophy producing bilateral neural foraminal narrowing, L5-S1 facet arthropathy with bilateral neural foraminal narrowing, and Schmorl's nodes at T12-L3. On 10/30/13, the worker reported an average low back pain level at 5-6/10 on the pain scale and on physical examination had a positive straight leg raise test. On 12/18/13, he rated his pain at a 4-5/10 on the pain scale. The worker was later seen on 3/6/14 by his orthopedic surgeon, complaining of lower back pain with left-sided radiating pain that he rated at 6-8/10 on the pain scale, worsened with prolonged sitting, bending backward and standing. Physical examination was significant for kyphoses of the lumbar spine, antalgic gait, no difficulty with heel and toe walking, no pelvic tilt, moderate to severe tenderness to palpation of the lower lumbar spine, negative straight leg raise bilaterally, 0/5 Waddell sign, negative FABER sign, slightly reduced leg strength 4/5, left leg muscle tension, and dysesthesias of the buttock and thigh. A repeat lumbar MRI was recommended as the previous one from 2012 was outdated.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar spine MRI without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines, low back - lumbar and thoracic, MRIs.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back section, MRI.

Decision rationale: MTUS Guidelines for diagnostic considerations related to lower back pain or injury require that for MRI to be warranted there needs to be unequivocal objective clinical findings that identify specific nerve compromise on the neurological examination (such as sciatica) in situations where red flag diagnoses (cauda equina, infection, fracture, tumor, dissecting/ruptured aneurysm, etc.) are being considered, and only in those patients who would consider surgery as an option. In some situations where the patient has had prior surgery on the back, MRI may also be considered. The MTUS also states that if the straight-leg-raising test on examination is positive (if done correctly) it can be helpful at identifying irritation of lumbar nerve roots, but is subjective and can be confusing when the patient is having generalized pain that is increased by raising the leg. The Official Disability Guidelines (ODG) state that for uncomplicated low back pain with radiculopathy MRI is not recommended until after at least one month of conservative therapy and sooner if severe or progressive neurologic deficit is present. The ODG also states that repeat MRI should not be routinely recommended, and should only be reserved for significant changes in symptoms and/or findings suggestive of significant pathology. In the case of this worker, it is unclear, from the documented reports, available for review, on pain and findings on physical examination of the prior months leading up to the request, whether or not the worker is noticing a worsening of his symptoms, a new and different symptom than previous reports, or if the worker is experiencing a continuation of his chronic pain, but with no further relief with the current treatment (medications). Pain levels went up and down over the months and straight leg raise was positive and then negative, which together doesn't suggest there was a particular pattern of worsening to suggest an MRI image would identify a new lesion to target. Also, there was no documented discussion of whether or not the worker was even interested in following through with another surgical procedure. Therefore, the lumbar MRI is not medically necessary.