

Case Number:	CM14-0097159		
Date Assigned:	07/28/2014	Date of Injury:	01/07/2011
Decision Date:	09/29/2014	UR Denial Date:	06/10/2014
Priority:	Standard	Application Received:	06/25/2014

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 Internal 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 patient is an injured worker with a lumbosacral spine condition. of injury was January 7, 2011. Regarding the mechanism of injury, the patient lifted a heavy piece of equipment and felt sharp pain in his lower back. Primary treating physician's report dated May 22, 2014 by orthopedic surgeon [REDACTED] documented subjective complaints of severe lower back pain and leg pain. He gets occasional sciatica which radiates into his left buttock and lateral thigh and calf. He has undergone at least 3 or 4 lumbar epidural injections without improvement in symptoms and 12 weeks of physical therapy with temporarily improved of his symptoms in the first year of his injury. The patient has had two doctors recommend a fusion procedure. On April 7, 2014, [REDACTED] offered the patient left L5-S1 laminotomy and discectomy surgery. Lumbar spine examination was documented. The patient appears uncomfortable. He arises from seated to standing slowly. He has normal lumbar lordosis and thoracic kyphosis. Gait is normal. Lumbar range of motion is restricted and painful in all planes. Motor and sensory function of the lower extremities is grossly intact. Patellar and achilles reflexes are brisk and equal bilaterally. Straight leg raise test is negative seated to 90 degrees bilaterally. MRI Lumbar spine 6/20/13 was reviewed. There is desiccation of the L3-L4, L4-L5, and L5-S1 discs. There is moderate loss of disc height at L5-S1. At L4-L5, there is a broad-based central disc extrusion which has migrated caudally into the left lateral which appears to elevate the left L5 nerve root in the lateral recess. There is a minimal central disc bulge at L5-S1 without significant central or foraminal stenosis. There is an annular tear in the L5-S1 disc centrally. Diagnoses were (1) degenerative disc L5-S1 with central disc protrusion and annular tear without central or foraminal stenosis, and (2) degenerative disc L4-L5 with left paracentral disc extrusion and left lateral recess stenosis. The patient stated that two other surgeons had offered him fusion surgery. [REDACTED] agreed that with the recommendation for fusion surgery. Given the findings of his

MRI which include degenerative discs at L4-L5 and L5-S1 as well as an annular tear at L5-S1, a fusion would address the degenerative changes that exist which are likely the source of his low back pain. Also noted on his 6/20/13 MRI is a left paracentral disc extrusion at the L4-L5 level which [REDACTED] believes underlies the patient's radiating left leg pain and numbness. [REDACTED] offered the patient left L4-L5 laminotomy and discectomy surgery in hopes that this surgery will resolve enough of his symptoms to bring his pain down to a tolerable level. To address his back pain, he would most likely necessitate a fusion of both L4-L5 and L5-S1. The patient elects to pursue the left L4-L5 laminotomy and discectomy surgery. Left L4-L5 laminotomy and discectomy surgery was recommended by [REDACTED]. [REDACTED] requested an updated lumbar MRI so that the surgery can be performed on the basis of the most recent imaging studies available. Qualified medical evaluator (QME) report dated 12/13/13 by orthopedic surgeon [REDACTED] documented a diagnosis of lumbar spine lumbago with lower extremity radiculopathy and that the patient is a candidate for discectomy surgery. Utilization review determination date was 6/10/14.

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 without contrast as an outpatient: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-310.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses imaging for low back conditions. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints that objective findings that identify nerve compromise are evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. Surgery is considered when serious spinal pathology or nerve root dysfunction, not responsive to conservative therapy and obviously due to a herniated disk, is detected. Surgical consultation is indicated for patients who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), radiating leg pain for more than one month, extreme progression of lower leg symptoms, evidence of a lesion that has been shown to benefit from surgical repair, and failure of conservative treatment to resolve disabling radicular symptoms. Magnetic resonance imaging (MRI) is the best imaging study to identify and define low back pathology. Medical records document that two orthopedic surgeons have recommended lumbosacral spine surgery. Diagnoses were degenerative disc L5-S1 with central disc protrusion and annular tear without central or foraminal stenosis, degenerative disc L4-L5 with left paracentral disc extrusion and left lateral recess stenosis, and lumbar spine lumbago with lower extremity radiculopathy. The patient had significant low back pain and lower extremity pain that has been refractory to treatment. On May 22, 2014, the patient's primary treating orthopedic surgeon recommended L4-L5 laminotomy and discectomy surgery and requested an updated lumbar MRI so that the surgery can be performed on the basis of the most recent imaging studies available. Given the

orthopedic surgeon's recommendation for surgery, the request for lumbar spine MRI to define spinal pathology and aid in surgical planning is supported. Therefore, the request for MRI of the lumbar spine without contrast as an outpatient is medically necessary.