

Case Number:	CM14-0187637		
Date Assigned:	11/18/2014	Date of Injury:	07/02/2009
Decision Date:	01/06/2015	UR Denial Date:	10/22/2014
Priority:	Standard	Application Received:	11/12/2014

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:

This 49 year old male sustained a work related injury on 7/2/2009. According to the Utilization Review, the mechanism of injury was reported to be injury from falling off of 4 foot high scaffolding. The current diagnoses are lumbago, sacroiliitis, and aseptic necrosis of the head and neck of femur. According to the progress report dated 10/9/2014, the injured workers chief complaints were increase in right leg pain with numbness and tingling that increases as the day goes on. The physical examination of the lumbar spine revealed normal range of motion with flexion, extension, and side bending. Rotation was limited. There was tenderness to palpation over L3-4 of the lumbar spinous process. On this date, the treating physician prescribed a repeat MRI of the lumbar spine, which is now under review. In addition to The MRI, the treatment plan included physical therapy for the low back and bilateral legs. According to the progress report, the injured worker received one epidural steroid injection six months prior, which resulted in temporary pain relief. On 7/17/2014, the injured worker had an initial MRI of the lumbar spine, which showed mild degenerative changes at L5-S1 and right neuroforaminal narrowing. The repeat MRI of the lumbar spine was prescribed specifically due to increased pain. When the MRI was prescribed work status was modified with restrictions, which included no lifting or carrying over 10 pounds, and no bending, crawling or kneeling. On 10/22/2014, Utilization Review had non-certified a prescription for MRI of the lumbar spine. The MRI was non-certified based on no documentation of severe or progressive neurological deficit. Objective examination findings did not document any change over the past year. The California MTUS ACEOM and Official Disability Medical Treatment Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI lumbar spine without dye: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303 and 304.

Decision rationale: This 49 year old male sustained a work related injury on 7/2/2009. According to the Utilization Review, the mechanism of injury was reported to be injury from falling off of 4 foot high scaffolding. The current diagnoses are lumbago, sacroiliitis, and aseptic necrosis of the head and neck of femur. According to the progress report dated 10/9/2014, the injured workers chief complaints were increase in right leg pain with numbness and tingling that increases as the day goes on. The physical examination of the lumbar spine revealed normal range of motion with flexion, extension, and side bending. Rotation was limited. There was tenderness to palpation over L3-4 of the lumbar spinous process. Treatment plan included a repeat MRI of the lumbar spine, physical therapy for the low back and bilateral legs. According to the progress report, the injured worker received one epidural steroid injection six months prior, which resulted in temporary pain relief. On 7/17/2014, the injured worker had an initial MRI of the lumbar spine, which showed mild degenerative changes at L5-S1 and right neuroforaminal narrowing now with request for repeating the study for increased pain complaints. The patient is without physiologic evidence of tissue insult, neurological compromise, or red-flag findings to support imaging request. Per ACOEM Treatment Guidelines for the Lower Back Disorders, under Special Studies and Diagnostic and Treatment Considerations, states Criteria for ordering imaging studies, include Emergence of a red flag; Physiologic evidence of tissue insult or neurologic dysfunction; Failure to progress in a strengthening program intended to avoid surgery; Clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination and electrodiagnostic studies. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist; however, review of submitted medical reports have not adequately demonstrated the indication for repeating the MRI of the Lumbar spine nor document any specific clinical findings to support this imaging study without demonstrated neurological deficits or acute progression in bilateral lower extremities. When the neurologic examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. The MRI lumbar spine without dye is not medically necessary and appropriate.