

Case Number:	CM14-0189399		
Date Assigned:	11/20/2014	Date of Injury:	06/25/2010
Decision Date:	02/11/2015	UR Denial Date:	10/29/2014
Priority:	Standard	Application Received:	11/13/2014

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 Rehab, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 a 40 year old male with a work injury dated 6/25/10. Patient states that on 6/25/2010 he was driving to a service call on a wet, unpaved road when his car rolled over and went into a small river. The car ended upside-down. He was able to get out of the car. Right after the accident patient was in shock and could not speak for about 30 minutes. His diagnoses include cervical and lumbar spine degenerative disc disease; lumbar disc protrusion. Under consideration is a request for a lumbar MRI. The patient has had prior treatment of physical therapy, acupuncture, chiropractic care and medication management. A 7/18/14 progress note reveals that the patient returns today for follow up. Since the last examination, he feels same and continues to complain of headaches; neck and back pain. He reports that the pain is associated with weakness in neck, back and legs; numbness and tingling in arms and legs and locking. The pain radiates to jaws, eyes, chest, abdomen, ribs, buttocks, shoulders, upper arms, forearms, elbows, wrists, hands, fingers, hips, legs, knees, feet, ankles and toes. He reports that lifting, bending, kneeling, walking and sitting aggravate his symptoms. He is currently off work. On examination of the lumbar spine, there was tenderness to palpation, guarding and spasms noted over the paravertebral region bilaterally. There were trigger points noticeable in the lumbar paraspinal muscles bilaterally. Manual muscle testing revealed 4/5 strength with flexion, extension and bilateral lateral bend. Range of motion was restricted due to pain and spasm. There was decreased lumbar range of motion. Sensory examination revealed decreased sensation at L5 dermatome bilaterally. The treatment plan included Cyclobenzaprine, Tramadol, Naproxen, Pantoprazole, cervical epidural and new lumbar MRI. Magnetic Resonance Imaging (MRI) report of the lumbar spine dated 07/28/13 documented that there was a 4 mm disc abnormality at L5-S1 with bilateral neural foraminal narrowing. MRI of the lumbar spine performed on September 13, 2012 demonstrated congenital mild central canal stenosis of the mid distal lumbar spine. A 3 mm

broad-based posterior disc protrusion/endplate osteophyte complex at L4-5. Mild to moderate central canal stenosis. Mild bilateral neural foraminal stenosis. Mild degenerative disc disease. A 3 mm broad-based posterior disc protrusion/endplate osteophyte complex at L5-S I. Mild degenerative disc disease. Mild facet arthropathy. Mild bilateral neural foraminal stenosis. A 5/7/14 rheumatology progress note states that the examination of the joints reveals MCP and PIP joints, wrist joints, elbows, shoulders, hips, knees, ankles, and feet are all within normal limits. There is no evidence of any synovial inflammation, synovial thickening, nodules, or limitation of movement of any particular joints. Range of motion of all the joints is normal, and they are enclosed herewith. Finger to floor touch is slightly limited to the extent that when he bends he lacks about 14 inches from the floor. His muscle strength of both upper and lower extremities, hands, shoulders, and neck are all within normal limits and they are 5/5. There is no evidence of any muscle fasciculation or fibrillation

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Spine MRI: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back (updated 08/22/14), MRIs (Magnetic Resonance Imaging)

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 (ODG) Low Back -MRIs (magnetic resonance imaging).

Decision rationale: Lumbar spine MRI is not medically necessary per the MTUS and the ODG Guidelines. The MTUS recommends imaging studies are reserved for cases in which surgery is considered, or there is a red-flag diagnosis. The guidelines state that 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. The ODG recommends a lumbar MRI when there is a suspected red flag condition such as cancer or infection or when there is a progressive neurologic deficit. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). The documentation submitted does not reveal progressive neurologic deficits, or a red flag diagnoses. The patient has had 2 prior lumbar MRI studies. There is no documentation how an MRI would alter this treatment plan. The request for MRI of the lumbar spine is not medically necessary.