

<b>Case Number:</b>	CM14-0197167		
<b>Date Assigned:</b>	12/05/2014	<b>Date of Injury:</b>	06/10/2009
<b>Decision Date:</b>	01/20/2015	<b>UR Denial Date:</b>	10/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/24/2014

### 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 49 year old male who was injured on 6/10/2009 after jumping/falling from a truck after losing his footing. He was diagnosed with lumbar radiculopathy and carpal tunnel syndrome. He was treated with physical therapy, surgery (right carpal tunnel release), acupuncture, epidural injection, and medications. MRI of the lumbar spine from 2011 showed a mild disc bulge at L4-5. On 9/23/14, the worker was seen by his pain specialist and reported persistent chronic low back pain with spasms causing him to not tolerate dishwashing or his home exercises for the prior two weeks. He was already almost completed his prescribed sessions of physical therapy and just received Flexeril. His standing tolerance was only a few minutes. Physical examination revealed lumbar muscle tension with subtle spasms and normal lower extremity neurological examination and seated straight leg testing was negative. He was then recommended to gradually introduce stretches, taper his opioid medication, which had been started previous to this visit and to follow-up in 4-6 weeks. Upon follow-up on 10/22/14, the worker reported falling twice due to his legs giving out and was using crutches and that physical therapy seemed to aggravate his pain. He reported his exercises being performed at home, but only limited tolerance was achieved with this. He was interested in an epidural injection, different physical therapy, and a stronger pain medication. He reported most of his pain being along his back and about 10% of his pain being down the backs of both his legs to his feet. Physical examination revealed tenderness to broad pattern across lower back into buttocks, normal neurological examination of the lower extremities as before, and negative straight leg testing. He was then recommended Medrol, MRI lumbar spine and epidural (although the provider at first did not agree with these, but the worker appeared to have insisted), and more physical therapy with a different facility.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI without contrast, lumbar:** Upheld

**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): 296-310. 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. The worker in this case, the requesting provider mentioned in his progress note on the same page as recommended MRI lumbar spine that he did not think an epidural injection would be helpful considering his lack of evidence of radiculopathy on previous imaging and physical examination. This review agrees with this assessment and is confused as to why the MRI was recommended if it was known to be not indicated at the time. Therefore, the MRI lumbar spine is not medically necessary.