

Case Number:	CM14-0048549		
Date Assigned:	06/25/2014	Date of Injury:	10/13/2010
Decision Date:	02/19/2015	UR Denial Date:	03/14/2014
Priority:	Standard	Application Received:	03/28/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Florida, New York, Pennsylvania
 Certification(s)/Specialty: Family Practice

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 original injury was sustained 12Oct10 while removing floor tiles as part of a demolition crew. He unexpectedly hit a large screw abruptly stopping the forward thrust of the crowbar precipitating the injury. The member had been coping but recently had noted a marked increase in continuous pain, which he quantified as 9/10 to his secondary treating provider, limiting his ability to walk and associated with bilateral radicular pain as well as numbness and tingling in both legs. This was also interfering with his sleep as well as provoking an increase in anxiety. He underwent at least 1 ESI in January without benefit and presented for consultation with his PTP. After this evaluation it was felt that a surgical opinion should be sought and to improve the utility of the consultation that a current MRI of the LS spine should be obtained in light of the change in symptoms. This review is to assess the denial of the requested MRI of the LS spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Lumbar Spine: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, MRIs

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 288, 295, 303.

Decision rationale: Notes from a secondary provider from 10Mar14 indicated that the member was experiencing continuous LBP radiating into the legs associated with numbness and tingling. The pain was quantified as 9/10. A reduced forward flexion to 30 degrees was noted. Notes provided as part of a psychiatric assessment, 17Sep13 detailed the members recollection of the inciting event 12Oct10. He was functioning as a part of a demolition crew. He was using a long crowbar to pry up tiles. During the process of forcing the crowbar under the tiles he unexpectedly contacted a screw in the floor obstructing his forward thrust abruptly and causing the injury. A supplemental report was filed by the PTP 18Feb14. The description of the injury was essentially the same. A conservative approach was taken at that time that included PT, medications and ESI's. This was reported to have provided some relief until recently when the pain returned with radicular symptoms. The MRI completed 12Jul12 is summarized (although the actual radiologists report was not provided) but describes a L paracentral disc protrusion abutting the L5 nerve root associated with mild to moderate central canal stenosis. A bilateral foraminal disc protrusion at this level abut the exiting L L4 nerve root. The partner of the PTP provided an evaluation of the members concerns on 5Feb14 in the absence of the PTP. The member reported that LBP continued radiating to the BLE, associated with numbness and tingling. Reports that he cannot walk any significant distance and depends on a crutch. He reports difficulty with sleep secondary to the pain pills and uses Zolpidem and anxiety for which he had been prescribed Lorazepam by the secondary treating provider. The member had undergone an ESI injection 10Jan14 that had provided fairly good relief until the day prior to the visit. Examination of the back revealed L/S tenderness and hypertonicity. Forward flexion limited to 30 degrees, DTR 2+ and paresthesia's consistent with involvement of L5 and S1 dermatomes. SLR was positive bilaterally. The member was reported to be taking Norco 7.5/325 6 per day, Cymbalta 60 1 a day, Lorazepan 1mg per day, Omeprazole bid and dulcolax. Based on the findings from the 2012 MRI, recurrent continuous LBP with radicular symptoms associated with paresthesia's consistent with involvement of the L5 and S1 nerve roots, demonstrated loss of motion in the L/S spine with positive SLR bilaterally and a failure of conservative measures that included PT, medications as well as ESI it was the opinion of the PTP and his associate that the member needed to be seen by a surgeon for consideration of a possible decompression or fusion procedure. To facilitate this consultation and in light of the changing physical exam it was felt important to obtain a current MRI to inform any changes in the local anatomy. The request was made under 722.1 Displacement of thoracic or lumbar intervertebral disc without myelopathy and 847.1 & .2 Sprain of Thoracic and Lumbar Spine. The secondary treating provider included the code 724.4 Radiculopathy. According to the ACOEM 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 and who would consider surgery as an option. If physiologic evidence indicates tissue insult or nerve impairment then an imaging test to define a potential cause such as magnetic resonance imaging [MRI] for neural or other soft tissues is warranted. While the actual radiologists written report is not provided the summary report appears to articulate adequately the areas of concern. Details provided through the psychiatric report, secondary providers notes and the supplemental report by the PTP adequately address the paucity of detail as described by the UR. As a tool to facilitate the opinion of the surgical consultant under these

circumstances to facilitate the best outcome for this member the MRI is necessary and should be approved. The request is not medically necessary and appropriate.