

Case Number:	CM15-0107506		
Date Assigned:	06/11/2015	Date of Injury:	01/22/2009
Decision Date:	07/17/2015	UR Denial Date:	05/11/2015
Priority:	Standard	Application Received:	06/03/2015

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: Texas, California

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 injured worker is a 58 year old male with an industrial injury dated 01/22/2009. The injured worker's diagnoses include residuals of musculoligamentous lumbosacral strain and lumbar disc disease. Treatment consisted of diagnostic studies and periodic follow up visits. In a progress note dated 02/02/2015, the injured worker reported lower back pain with numbness in the left leg. Objective findings revealed pain with lumbar range of motion. The treating physician reported that the Magnetic Resonance Imaging (MRI) dated 11/19/2014 revealed moderate to severe degenerative changes in the lumbar area, old compression fracture of the L1 vertebrae and a 6mm retrolisthesis of L5-S1. In a qualified medical evaluation dated 3/31/2015, physical exam revealed normal lumbar range of motion and tenderness to palpitation on the left lumbar paraspinal muscles extending up to the left sacroiliac (SI) joint area. The treating physician prescribed Magnetic Resonance Imaging (MRI) of the lumbar spine now under review. Patient has received an unspecified number of PT visits for this injury. The patient has used a back brace and TENS unit for this injury. Patient had received injections for this injury. Per note dated 3/31/15, physical examination of the lumbar spine revealed normal heel-toe walk and normal gait, tenderness on palpation, normal ROM, negative SLR, normal strength and reflexes and decreased sensation in left foot. The patient has had EMG of LE that revealed bilateral L5-S1 radiculopathy. The EMG report was noted in a note dated 5/26/2010. Patient sustained the injury due to MVA. The medication list includes Lyrica and Tylenol. Any surgical or procedure note related to this injury were not specified in the records provided. Patient sustained the injury due to lifting a heavy water bag.

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: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back (updated 4/29/15), 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 Treatment in Workers' Comp., online Edition Chapter: Low Back (updated 05/15/15) MRIs (magnetic resonance imaging).

Decision rationale: Per the ACOEM low back guidelines cited below "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 an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures)." ACOEM/MTUS guideline does not address a repeat MRI. Hence, ODG is used. Per ODG low back guidelines cited below, "Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation)." The treating physician reported that the Magnetic Resonance Imaging (MRI) dated 11/19/2014 revealed moderate to severe degenerative changes in the lumbar area, old compression fracture of the L1 vertebrae and a 6mm retrolisthesis of L5-S1. Any significant changes in objective physical examination findings since the last study, which would require a repeat study, were not specified in the records provided. Physical examination of the lumbar spine revealed normal heel-toe walk and normal gait, tenderness on palpation, normal ROM, negative SLR, normal strength and reflexes. Patient did not have evidence of severe or progressive neurologic deficits that are specified in the records provided. Finding indicating red flag pathologies were not specified in the records provided. The history or physical exam findings did not indicate pathology including cancer, infection, or other red flags. As per records provided patient has received an unspecified number of PT visits for this injury until date. A detailed response to complete course of conservative therapy including PT visits was not specified in the records provided. Previous PT visit notes were not specified in the records provided. A recent lumbar spine X-ray report is not specified in the records provided. A plan for an invasive procedure of the lumbar spine was not specified in the records provided. MRI of the lumbar spine is not medically necessary for this patient.