

Case Number:	CM15-0182637		
Date Assigned:	09/23/2015	Date of Injury:	02/25/2012
Decision Date:	11/09/2015	UR Denial Date:	08/17/2015
Priority:	Standard	Application Received:	09/16/2015

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 46 year old male, who sustained an industrial injury on 2-25-2012. Medical records indicate the worker is undergoing treatment for lumbosacral myoligamentous sprain-strain, mechanical-discogenic low back pain, lumbar 4-5 left greater than right disc protrusion, lumbosacral lateralizing protrusion with moderately severe neural encroachment abutting and displacing the exiting lumbar 5 nerves and right active lumbar 5 radiculopathy. A recent progress report dated 8-3-2015, reported the injured worker complained of low back pain that is the worst pain possibly imagined on the pain scale, with numbness and tingling and difficulty sleeping. The progress note reports the injured worker had surgery approved in 3-2014, but the injured worker never returned phone calls. Physical examination revealed lumbar flexion 80 degrees, extension 20 degrees and tenderness to the lumbar paraspinal muscles and bilateral sacroiliac joints. The patient has had worsening of lumbar pain in last 6 months. The patient has had positive pinwheel test and 3-4/5 strength. Treatment to date has included physical therapy, home exercise program, multi-stimulation unit, Norco, Naprosyn and Flexeril. The most recent magnetic resonance imaging was dated 2-29-2012 and showed multi-level disc bulging. The physician is requesting lumbar magnetic resonance imaging. On 8-17-2015, the Utilization Review noncertified a request for a lumbar magnetic resonance imaging. The patient has had MRI of the lumbar spine on 2/29/12 that revealed disc protrusions, foraminal narrowing, and degenerative changes and EMG of lower extremity on 4/18/12 that revealed L5 radiculopathy. Patient was approved 32 PT visits for lumbar spine. Patient had received lumbar ESI for this injury.

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: Overturned

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers' Comp., online Edition Low Back (updated 09/22/15) MRIs (magnetic resonance imaging).

Decision rationale: Request: MRI of the lumbar spine. 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 (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation)." The patient has had MRI of the lumbar spine on 2/29/12 that revealed disc protrusions, foraminal narrowing, and degenerative changes and EMG of lower extremity on 4/18/12 that revealed L5 radiculopathy. The patient has had diagnoses of lumbosacral myoligamentous sprain-strain, mechanical-discogenic low back pain, lumbar 4-5 left greater than right disc protrusion, lumbosacral lateralizing protrusion with moderately severe neural encroachment abutting and displacing the exiting lumbar 5 nerves and right active lumbar 5 radiculopathy. A recent progress report dated 8-3-2015, reported the injured worker complained of low back pain that is the worst pain possibly imagined on the pain scale, with numbness and tingling and difficulty sleeping. Physical examination revealed lumbar flexion 80 degrees, extension 20 degrees and tenderness to the lumbar paraspinal muscles and bilateral sacroiliac joints. The patient has had worsening of lumbar pain in last 6 months. The patient has had positive pinwheel test and 3-4/5 strength. There is possibility of significant neurocompression. The patient has been treated already with medications and physical therapy. A MRI of the lumbar spine is deemed medically appropriate and necessary for this patient.