

<b>Case Number:</b>	CM15-0188979		
<b>Date Assigned:</b>	09/30/2015	<b>Date of Injury:</b>	03/25/2002
<b>Decision Date:</b>	11/18/2015	<b>UR Denial Date:</b>	09/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2015

### 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: California  
 Certification(s)/Specialty: Emergency Medicine

### 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 64 year old, male who sustained a work related injury on 3-25-02. A review of the medical records shows he is being treated for low back pain. Current medications include Norco, Protonix and Ranitidine. In the progress notes, the injured worker reports bilateral back pain with radiation to posterior thigh. The pain is "worsening" since last visit. He rates his average pain level a 7 out of 10. It is a 3 out of 10 with pain medication and a 9 out of 10 without pain medication. He reports Norco "improves pain 75% without side effects." On physical exam dated 8-26-15, he has tenderness over the lumbar paraspinous area and sacroiliac joint. He has mild spasm. He has some decrease in lumbar range of motion. MRI of lumbar spine dated 5-26-09 reveals "minimal disc dehydration at L3-4 with very minimal disc bulging. Minimal disc dehydration L5-S1 with mild 2mm broad based disc bulging with a small amount of extrusion posterocentrally 3mm down onto the S1 vertebral body but barely touching the thecal sac and not touching the nerve roots within the spinal canal. Only minimal disc bulging in the neural foramina L3-4, L4-5, and L5-S1. Mild facet degenerative changes L3 to S1 and minimal in the remainder of the lumbar spine." The treatment plan includes a repeat order for an MRI of the lumbar spine, a refill of Norco and a repeat request for a lumbar epidural steroid injection. The Request for Authorization dated 8-26-15 has a request for an MRI of the lumbar spine. In the Utilization Review dated 9-8-15, the requested treatment of an MRI of the lumbar spine is not medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations, Special Studies.

**Decision rationale:** The request is for MRI of the lumbar spine. The MTUS guidelines support the use of advanced imaging, including MRI, for a significant change in symptoms with the presence of red flags, or when cauda equina, tumor, infection, or fracture are strongly suspected and plain film radiographs are negative. Within the first three months after onset of acute low back symptoms, surgery is considered only when serious spinal pathology or nerve root dysfunction not responsive to conservative therapy (and obviously due to a herniated disk) is detected. Disk herniation, characterized by protrusion of the central nucleus pulposus through a defect in the outer annulus fibrosis, may impinge on a nerve root, causing irritation, back and leg symptoms, and nerve root dysfunction. The presence of a herniated disk on an imaging study, however, does not necessarily imply nerve root dysfunction. Studies of asymptomatic adults commonly demonstrate intervertebral disk herniations that apparently do not cause symptoms. Some studies show spontaneous disk resorption without surgery, while others suggest that pain may be due to irritation of the dorsal root ganglion by inflammogens. Regarding the injured worker, an MRI had been previously performed. Since that time, there is no clear documentation of red flag findings on exam, or a situation that may respond to surgery, that would require imaging prior to consideration. These include: severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair; failure of conservative treatment to resolve disabling radicular symptoms. The documentation provided does not meet a threshold to suggest a medical benefit from repeat MRI. Therefore, the request as submitted is not medically necessary.