

<b>Case Number:</b>	CM15-0022355		
<b>Date Assigned:</b>	02/11/2015	<b>Date of Injury:</b>	11/07/1993
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	01/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/06/2015

### 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: Preventive Medicine, Occupational 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 69 year old female, who sustained an industrial injury on November 7, 1993. She has reported injury following a fall. The diagnoses have included low back pain, carpal tunnel syndrome, radicular pain, and headache. Treatment to date has included ice applications, heat applications, medications, transcutaneous electrical nerve stimulation, rest, position changes, stellate blocks, radiological imaging, and physical therapy. Currently, the IW complains of shooting pain with numbness and tingling in the upper and mid-back. She reports having difficulty with activities of daily living, including walking. Physical findings reveal a normal gait, no perceptible limp, no assistive devices used in ambulation. She is noted to move in a slow cautious manner. Her lumbar spine appeared within normal limits on visual inspection, no tenderness noted to the greater trochanter, sacrum, coccyx, or sacroiliac joint. She is positive for tenderness to the lower bilateral facet joints, iliolumbar region and paraspinal muscles bilaterally. Range of motion is noted to be 50%. The records indicate a magnetic resonance imaging of the lumbar spine was completed on January 24, 2014, which revealed disc protrusion at L4-5, and L5-S1. On January 29, 2015, Utilization Review non-certified of lumbar magnetic resonance imaging without contrast. The ACOEM, MTUS guidelines were cited. On February 5, 2015, the injured worker submitted an application for IMR for review of lumbar magnetic resonance imaging without contrast.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar MRI:** 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): 297, 303, 304, 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back chapter, MRI (magnetic resonance imaging) section.

**Decision rationale:** The MTUS Guidelines do not recommend the routine use of MRI with low back complaints. MRI should be reserved for cases where there is physiologic evidence that tissue insult or nerve impairment exists, and the MRI is used to determine the specific cause. MRI is recommended if there is concern for spinal stenosis, cauda equine, tumor, infection or fracture is strongly suspected, and x-rays are negative. The ODG recommends repeat MRI when there is significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). The injured worker had an MRI on 1/24/2014, and this request is to assess progression of degeneration. There are no significant history or examination findings to indicate worsening neurologic compromise that may necessitate a repeat MRI. The request for Lumbar MRI is determined to not be medically necessary.