

Case Number:	CM15-0217668		
Date Assigned:	11/09/2015	Date of Injury:	07/01/1982
Decision Date:	12/29/2015	UR Denial Date:	10/13/2015
Priority:	Standard	Application Received:	11/05/2015

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 an 81-year-old male, who sustained an industrial injury on 7-1-1982. The medical records indicate that the injured worker is undergoing treatment for spondylolisthesis at L4-L5 level, lumbar spinal stenosis, and lumbar radiculopathy. According to the progress report dated 9-23-2015, the injured worker presented with complaints of low back pain. On a subjective pain scale, he rates his pain 5 out of 10, and when it is exacerbated reaches 10 out of 10 in severity. The patient had worsening of pain on standing up and had radicular symptoms. The physical examination of the lumbar spine reveals tenderness over the midline at L4-5. The current medications are Acetaminophen and Gabapentin. Previous diagnostic studies include x-rays (2013) and MRI of the lumbar spine (2011). The treating physician described the x-ray as "progression of L4 spondylolisthesis and facet arthropathy since 2011" and the MRI as "L4-5 moderate-to-severe central canal stenosis secondary to degenerative grade I anterolisthesis, severe bilateral facet arthropathy, and mild degenerative disk disease. L1-2 central disc herniation and extrusion, resulting in mild central canal stenosis". Treatments to date include medication management, physical therapy, home exercise program, acupuncture, and transforaminal epidural steroid injection. The original utilization review (10-13-2015) had non-certified a request for MRI of the lumbar spine. The patient had received a lumbar ESI for this injury. The patient has had a history of prostate and bladder cancer. The patient's surgical history includes cataract and cardiac surgery. Physical examination of the lumbar spine on 10/5/15 revealed normal gait, full ROM, no tenderness on palpation, negative SLR, normal strength and sensation and hypoactive left ankle reflex.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI with and without contrast, lumbar spine, per 09/25/15 order Qty: 1.00: Overturned

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (updated 12/02/15)MRIs (magnetic resonance imaging).

Decision rationale: MRI with and without contrast, lumbar spine, per 09/25/15 order Qty: 1.00. Per the ACOEM, low back guidelines cited "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." The patient had diagnoses of spondylolisthesis at L4-L5 level, lumbar spinal stenosis, and lumbar radiculopathy. According to the progress report dated 9-23-2015, the injured worker presented with complaints of low back pain. On a subjective pain scale, he rates his pain 5 out of 10, and when it is exacerbated reaches 10 out of 10 in severity. The patient had worsening of pain on standing up and had radicular symptoms. The physical examination of the lumbar spine reveals tenderness over the midline at L4-5. The last MRI of the lumbar spine was in 2011. There has been a significant change in the status of the patient since then. The patient has had a history of prostate and bladder cancer. He has a hypoactive left ankle reflex. The patient has chronic pain with significant objective findings and a history of prostate cancer. There is a possibility of significant neurocompression. The patient has been treated already with medications and physical therapy. A MRI would be appropriate evaluate the symptoms further and to rule out any red flag pathology. The request of the MRI with and without contrast, lumbar spine, per 09/25/15 order Qty: 1.00 is deemed medically appropriate and necessary for this patient.