

<b>Case Number:</b>	CM15-0223645		
<b>Date Assigned:</b>	11/19/2015	<b>Date of Injury:</b>	03/14/2013
<b>Decision Date:</b>	12/30/2015	<b>UR Denial Date:</b>	11/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/13/2015

### 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, Indiana, New  
York Certification(s)/Specialty: Internal 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 33-year-old male who sustained an industrial injury on 03-14-2013. A review of the medical records indicated that the injured worker is undergoing treatment for chronic low back pain with radiculopathy, blunt force trauma with loss of consciousness, headaches and post-traumatic stress disorder. According to the treating physician's progress report on 10-27-2015 and 11-02-2015 the injured worker continues to experience low back pain radiating to both legs to the feet and improvement in headaches. The recent lumbar epidural steroid injection performed on 10-08-2015 lasted only approximately one day then re-occurred with pain now in both lower extremities and distinctly different headaches than from the original trauma. It was also reported that initially the lower extremity pain was on the right side only associated with numbness. According to the progress report dated 09-21-2015 the lower, back pain traveled down to the bilateral buttocks. Observation revealed normal lordosis and no scars. Examination demonstrated tenderness in the lumbar axial and bilateral paraspinal muscles with spasm on the left. There were no signs of edema or induration. A positive straight leg raise with low back pain was documented at approximately 90 degrees. Range of motion was noted as flexion at 60 degrees, extension at 15 degrees and bilateral lateral bending and bilateral lateral rotation at 20 degrees each. Motor strength in the bilateral lower extremities was intact. Deep tendon reflexes were absent at the knees and 1+ at the ankles bilaterally. Sensation to light touch and pinprick over the right medial calf was decreased. An official report of a lumbar spine magnetic resonance imaging (MRI) performed on 07-09-2015 was included in the review along with the operative report of 10-08-2015. Prior treatments have included diagnostic testing,

neurology consultation, physical therapy to lumbar spine, Medrol Dosepak, L4-5 epidural steroid injection on 10-08-2015 with fluoroscopy and epidurogram and medications. Current medications were listed as Norco, Zoloft and Naproxen. Treatment plan consists of bilateral two level lumbar facet nerve blocks and the current request for a lumbar spine magnetic resonance imaging (MRI) without contrast. On 11-05-2015, the Utilization Review determined the request for a lumbar spine magnetic resonance imaging (MRI) without contrast was not medically necessary.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **MRI Lumbar Spine with and without contrast: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 13th Edition (web), 2015, Low Back.

**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 section, MRI lumbar spine.

**Decision rationale:** Pursuant to the Official Disability Guidelines, MRI of the lumbar spine with and without contrast is not medically necessary. MRIs of the test of choice in patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy, it is not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and findings suggestive of significant pathology. Indications (enumerated in the official disability guidelines) for imaging include, but are not limited to, lumbar spine trauma, neurologic deficit; uncomplicated low back pain with red flag; uncomplicated low back pain prior lumbar surgery; etc. ACOEM states unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients not respond to treatment and who would consider surgery an option. See the ODG for details. In this case, the injured worker's working diagnoses are chronic low back pain with radiculopathy, blunt force trauma with loss of consciousness, headaches and post-traumatic stress disorder. Date of injury is March 14, 2013. Request authorization is October 29, 2015. The documentation shows the injured worker and an MRI of the lumbar spine July 9, 2015. A spine specialist/pain management orthopedic surgeon performed a lumbar epidural steroid injection with a consultation. The documentation shows the treating provider is concerned about CSF leak secondary procedure and wants a second MRI lumbar spine (19 days after the procedure). There was a peer-to-peer conference call between the utilization reviewer and the treating provider's physician assistant. The documentation indicates the injured worker has not followed up with the spine surgeon/pain management provider that performed the procedure for follow-up. The injured worker followed up the orthopedic surgeon (a second provider) on October 27, 2015. According to the October 27, 2015 progress note, the epidural steroid injection provided gave relief for approximately one day. Pain returned with radiation down both legs and feet with headaches. The injured worker has a history of migraines, but the headaches were now

positional. There was no follow-up with the spine specialist/pain management provider that administered the epidural steroid injection. Objectively, there was tenderness of the lower lumbar region and positive straight leg raising. There was a normal sensory and motor examination. The documentation shows the only new symptoms experienced by the injured worker was low back pain radiating to both lower extremities and positional headaches. The treating provider followed up with the orthopedic surgeon 19 days after the epidural steroid injection. The injured worker has still not followed up with the treating provider that administered the epidural steroid injection. There were no unequivocal objective findings that identify specific nerve compromise on the neurologic examination sufficient to warrant imaging. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and findings suggestive of significant pathology. There is no documentation indicating a significant change in symptoms and/or objective clinical findings. New symptoms included radiculopathy involving both legs subjectively and positional headaches (with a history of migraines). Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, no documentation showing follow-up with the spine specialist/pain management provider that performed a lumbar epidural steroid injection to evaluate the injured worker's symptoms, no unequivocal objective findings that identify specific nerve compromise on the neurologic evaluation and no significant change in symptoms and/or objective findings suggestive of significant pathology, MRI of the lumbar spine with and without contrast is not medically necessary.