

<b>Case Number:</b>	CM15-0033710		
<b>Date Assigned:</b>	02/27/2015	<b>Date of Injury:</b>	07/09/2003
<b>Decision Date:</b>	04/09/2015	<b>UR Denial Date:</b>	01/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/23/2015

### 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, Illinois

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 59 year old female, who sustained an industrial injury on 07/09/2003. She has reported low back pain and neck pain. The diagnoses have included cervicgia, cervical radiculopathy; and lumbar radiculopathy. Treatment has included medications, injections, and physical therapy. Medications have included Cyclobenzaprine, Tramadol, Gabapentin, and Oxycodone. A progress note from the treating physician, dated 11/17/2014, documented a follow-up visit with the injured worker. The injured worker reported increased neck pain with radiation to the bilateral upper extremities; left and right knee pain; and low back pain, rated at 7/10 on the visual analog scale, with radiation to the bilateral lower extremities. Objective findings included significant tenderness in the paraspinous musculature of the lumbar spine region, bilaterally; and midline tenderness is noted in the lumbar region. Request is being made for Lumbar Spine MRI. On 01/29/2015 Utilization Review noncertified a prescription for Lumbar Spine MRI, The Official Disability Guidelines were cited. On 02/09/2015, the injured worker submitted an application for IMR for review of Lumbar Spine MRI.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar Spine MRI:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304-305.

**Decision rationale:** The injured worker sustained a work related injury on 07/09/2003. The medical records provided indicate the diagnosis of cervicalgia, cervical radiculopathy; and lumbar radiculopathy. Treatment has included medications, injections, and physical therapy. Medications have included Cyclobenzaprine, Tramadol, Gabapentin, and Oxycodone. The medical records provided for review do not indicate a medical necessity for Lumbar Spine MRI. The records indicate the injured worker had lumbar fusion in 2012; her condition has remained stable since the previous visit. The MTUS recommends that imaging studies should be reserved for case in which surgery is considered or when there is a possibility of progressive neurological disorder. This is to avoid confusing pre-existing conditions with problems from a recent injury.