

<b>Case Number:</b>	CM14-0121580		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	05/08/2009
<b>Decision Date:</b>	10/16/2014	<b>UR Denial Date:</b>	07/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/01/2014

### 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. The expert reviewer is Board Certified in Family Practice and is licensed to practice in Texas & Mississippi. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 51-year-old female who reported an injury on 05/09/2009. The mechanism of injury was not included. The diagnoses included back pain and lumbar radiculopathy. The past treatments included medication, chiropractic care, injections and physical therapy. An MRI, dated 07/29/2010, revealed likely extruded disc material at the L1-2 disc, mild desiccation of the L3-4 disc, mild bilateral L3-4 neural foraminal stenosis, mild facet joint arthropathy bilaterally at L3-4, L4-5, and on the left at L5-S1, and moderate facet joint arthropathy and hypertrophy at the right of L5-S1. The surgical history was not relevant. The progress note, dated 07/02/2014, noted the injured worker complained of increasing back pain to the lumbar and left lower back area rated at 8/10. The pain radiated down to her bilateral hips and left leg. It was noted the symptoms started 5 years ago. The physical examination revealed severe tenderness to the right sciatic notch and lower lumbar spine, a positive seated straight leg raise on the right, negative Waddell's sign, and lower extremity strength 5/5 bilaterally, sensation intact to light touch, and deep tendon reflexes were intact. The medications included Norco 10/325 mg, Flexeril 10 mg, and Prilosec 20 mg. The treatment plan requested an MRI of the lumbar spine for further evaluation of x-rays performed that day, which revealed moderate loss of disc space at L4-5 and L5-S1 with facet arthropathy. The physician further notes that the injured worker had received an L5-S1 facet joint injection which did not provide significant relief. The Request for Authorization form was submitted for review on 07/08/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI Lumbar Spine w/o dye: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 12th Edition (web), 2014, Low Back, MRI

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, MRIs (magnetic resonance imaging).

**Decision rationale:** The injured worker had back pain radiating to her bilateral hips and left lower extremity. The previous MRI dated 07/29/2010, demonstrated facet joint arthropathy at L4-5 and L5-S1, without significant disc bulge or protrusion. The lumbar x-ray, noted on 07/02/2014, demonstrated moderate loss of disc space at L4-5 and L5-S1 with facet arthropathy. She is noted to have radicular symptoms. However, there were no objective findings of radiculopathy on physical examination. The California MTUS/ACOEM Guidelines recommend an MRI for the emergence of a red flag, physiologic evidence of tissue insult or neurovascular dysfunction (e.g., weakness, edema), failure to progress in a strengthening program intended to avoid surgery, clarification of the anatomy prior to an invasive procedure, or to further evaluate the possibility of potentially serious pathology, such as a tumor. The Official Disability Guidelines further state repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. There was no evidence of a red flag, or a significant change in the injured worker's condition. The injured worker did not have significant weakness or evidence of tissue insult or neurologic dysfunction. There was no documentation of failure to progress in a strengthening program, and there was no indication of planned surgical intervention. As such, the request is not medically necessary.