

Case Number:	CM14-0142070		
Date Assigned:	09/10/2014	Date of Injury:	10/08/2012
Decision Date:	10/10/2014	UR Denial Date:	08/28/2014
Priority:	Standard	Application Received:	09/03/2014

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 and is licensed to practice in Maryland. 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 patient is a 52 year old male with a work injury dated 10/8/12. The diagnoses include contusion of the lumbosacral spine; lumbosacral strain/sprain; lumbar herniated nucleus pulposus with left L5 radiculopathy. Under consideration is a request for MRI of the lumbar spine. Per documentation a handwritten, somewhat illegible physician report dated 8/20/14 that states that the pain is as still severe with burning sensation and weakness. The lumbar spine pain is an 8/ 10 and was constant with numbness. There was negative tingling. The pain was aggravated by bending in the same positing for a long time activities. The pain was constant. On examination the straight leg raise was 80/70 and 80/70 with lumbar pain noted. The range of motion of the lumbar spine was decreased. The deep tendon reflex was 2/0 and 2/0. Treatment plan included magnetic resonance imaging. A lumbar MRI dated 7/21/13 documented that at L5-S1 there was 7-8 mm disc protrusion with central canal and foraminal stenosis A 9/11/14 document states that the patient is status post hernia repair on 9/10/14 and could not be examined. The patient complains of severe low back pain which is 10/10, constant, radiates shooting pains to the legs without tingling and numbness. It is decreased with rest and meds.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the Lumbar Spine Without Contrast: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 303-304.

Decision rationale: MRI of the lumbar spine without contrast is not medically necessary per the MTUS ACOEM guidelines. The guidelines state that indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. The documentation submitted does not reveal a plan for lumbar surgery or evidence of red flag conditions. The patient has had a prior lumbar MRI in July of 2013. The documentation is not clear on how a repeat MRI would change the management of the patient. The request for MRI of the Lumbar Spine Without Contrast is not medically necessary.