

<b>Case Number:</b>	CM14-0145097		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	08/31/2011
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	09/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/08/2014

### 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 Physical Medicine and Rehabilitation, and is licensed to practice in California. 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 43-year-old male with a reported date of injury on 08/31/2011. The mechanism of injury was due to a fall. The diagnoses included lumbar strain/sprain and degenerative disc disease. The past treatments included pain medication and physical therapy. The MRI on 10/13/2011 revealed L5-S1 disc protrusion causing marked stenosis of the right lateral recess and neural foramen along with L4-5 disc protrusion causing marked stenosis of the left lateral recess and neural foramen. There was no relevant surgical history documented in the records. The subjective complaints on 05/28/2014 included low back pain and right leg pain. The physical examination of the lumbar spine noted tenderness to palpation to the L5-S1 midline and paraspinals. There was no evidence of muscle spasms. The straight leg raise was negative bilaterally. The motor strength in all muscle groups, upper and lower extremities, was rated 5/5. The sensation was intact to light touch and pinwheel stimulation throughout all dermatomes of the upper and lower extremities. The medications included tramadol, gabapentin, ibuprofen, and Lidoderm patch. The treatment plan was to order an MRI of the lumbar spine and a 5 view x-ray of the lumbar spine. A request was received for an MRI of the lumbar spine and radiographs lumbar spine 5 views. A rationale was not provided with the request. The Request for Authorization form was not provided with the records submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI Lumbar Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 16 Eye Chapter Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines; Low Back Sections, MRI

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic MRIs (magnetic resonance imaging).

**Decision rationale:** The request for MRI Lumbar Spine is not medically necessary. The Official Disability Guidelines state repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The injured worker has chronic low back pain and had an MRI of the lumbar spine on 10/13/2011. There was no significant or progressive symptoms or findings suggestive of significant pathology to support the use of a repeat MRI. Additionally, the specific rationale for the repeat MRI was not provided. As there were no symptoms and/or findings suggestive of significant pathology documented in the notes, the request is not supported.

**Radiographs Lumbar Spine, 5 Views:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back Section Radiographs

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305..

**Decision rationale:** The request for Radiographs Lumbar Spine, 5 Views is not medically necessary. The California MTUS/ACOEM Guidelines state lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. The injured worker has chronic low back pain. There were no acute symptoms or red flags documented in the notes to support the use of radiographs. In the absence of red flags, the request is not supported by the guidelines. As such, the request is not medically necessary.