

Case Number:	CM14-0168677		
Date Assigned:	10/16/2014	Date of Injury:	12/14/2000
Decision Date:	11/18/2014	UR Denial Date:	09/10/2014
Priority:	Standard	Application Received:	10/13/2014

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 Medicine 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:

This is a 49 years old male patient who sustained an injury on 12/14/2000. He sustained the injury due to a single, direct trauma to the low back. He struck his left knee against a metallic vibrator in 2003. The current diagnoses include displacement of the lumbar intervertebral disc without myelopathy and unspecified internal derangement of knee. Per the doctor's note dated 10/10/14, he had complaints of pain in the low back and left knee with radiation to the left leg at 8/10 with tingling and weakness in the left leg. The physical examination of the lumbar spine revealed range of motion- forward flexion 40 degrees, extension 10degrees, and side bending 15 degrees to the right and 15 degrees to the left and limited rotation; tenderness to palpation over the bilateral lumbar paraspinous muscles consistent with spasms; positive lumbar facet loading maneuver bilaterally, positive straight leg raise test on the left in the seated position to 50 degrees, the left knee- full range of motion, tenderness to palpation over the medial joint line, 4+/5 strength on the left ankle plantar flexion, diminished sensation in the left L5 and S1 dermatomes of the lower extremities. The current medications list includes Naproxen, Tramadol, Prilosec, Venlafaxine ER, Lyrica and Ambien. He has had Lumbar MRI dated 08/04/2008 which revealed at L4-5 a 2 mm disc bulge posteriorly and an annular disc tear, and at L5-S1 a 2 mm disc bulge posteriorly to the left also with an annular disc tear; lumbar MRI dated 3/17/2014 which revealed the same disc degenerative changes and annular tears at L4-5 and L5-S1 with slightly greater bulging when compared to a scan from 2011; left knee MRI dated 12/1/2003 which revealed mild degenerative changes. He has undergone left knee surgery in 2005. He has had physical therapy visits and multiple epidural steroid injections for this injury. Per the record of the notes of 2007, the patient had left lower extremity symptoms suggestive of lumbar radiculopathy since that time in 2007.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI lumbar 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 based on Non-MTUS Citation Official Disability Guidelines (ODG); Chapter: Low Back (updated 10/28/14) MRIs (magnetic resonance imaging)

Decision rationale: Per the ACOEM low back guidelines cited above "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures)." Patient has already had a lumbar MRI dated 08/04/2008 which revealed at L4-5 a 2 mm disc bulge posteriorly and an annular disc tear, and at L5-S1 a 2 mm disc bulge posteriorly to the left also with an annular disc tear; lumbar MRI dated 3/17/2014 which revealed the same disc degenerative changes and annular tears at L4-5 and L5-S1 with slightly greater bulging when compared to a scan from 2011. Per ODG low back guidelines cited above, "Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neuro compression, recurrent disc herniation)." Per the record of the notes of 2007, the patient had left lower extremity symptoms suggestive of lumbar radiculopathy since that time in 2007. Significant changes in the patient's condition since these previous imaging studies, that would require a repeat MRI are not specified in the records provided. Patient does not have any progressive neurological deficits that are specified in the records provided. The history or physical exam findings do not indicate findings suspicious for tumor, infection, fracture, neuro compression, or other red flags. Details of the response to previous conservative treatment with rehabilitation are not specified in the records provided. The medical necessity of MRI lumbar without contrast is not established for this patient.