

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0177610 | | |
| Date Assigned: | 10/31/2014 | Date of Injury: | 02/22/2013 |
| Decision Date: | 12/08/2014 | UR Denial Date: | 09/26/2014 |
| Priority: | Standard | Application Received: | 10/27/2014 |

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 35-year old security guard reported an injury to his back due striking it on the edge of a counter after stooping to pick up a piece of trash from the floor on 2/22/13. Initial treatment included medications and physical therapy. Chiropractic manipulation and acupuncture were added later when his pain did not respond to initial measures. The patient has not worked since his injury. His medical history is notable for morbid obesity (BMI over 40) and for hypertension. An MRI of the lumbosacral spine performed 5/26/13 showed diffuse degenerative changes with a 7 mm left paracentral disc protrusion at L5-S1. Per an AME report dated 4/16/14 neurodiagnostic studies performed 10/22/13 showed L S1 radiculopathy. However, the records contain the report from the studies performed 10/22/14, which states that the findings are most compatible with mild peripheral neuropathy and possible left L5 nerve root dysfunction. The AME requested a repeat LS MRI which was performed on 4/22/14. It also showed diffuse degenerative changes. The left paracentral disc protrusion at L5-S1 had regressed, and was 3 mm rather than 7 mm. A right paracentral disc protrusion at L4-5 had progressed to a size of 4 mm. The patient was seen by a nurse practitioner in the primary treating physician's office on 7/8/14. Documented symptoms included severe constant back pain radiating to both legs and feet, with headaches and jaw pain. Exam was notable for decreased back and right knee range of motion. Diagnoses included disc protrusions T11-S1; spinal stenosis, multi-level, T11-S1; degenerative disc disease; radiculopathy, lumbar spine; and small effusion right knee. The plan included a request for a lumbar brace only. A hand-written report from the same date also requested MRIs of the LS spine and R knee "per AME 4/16/14". An 8/22/14 note by the same provider states that the patient is still having back pain which radiates to both legs. He is also having erectile problems. Exam findings include only paraspinal tenderness and decreased back range of motion. No neurological exam or findings of radiculopathy are documented. Diagnoses include

disc protrusions T11-S1; spinal stenosis, multi-level, T11-S1; degenerative disc disease; lumbar spine radiculopathy; and erectile dysfunction. The plan includes a statement that "We are making a second request for an updated MRI of the lumbar spine". The patient remains at total disability status.

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 Page(s): 303-309.

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

Decision rationale: The MTUS reference cited above states that unequivocal findings on neurologic exam that identify specific nerve root compromise provide enough evidence to warrant an MRI. When the neurologic findings are less clear, other physiologic evidence of nerve dysfunction should be obtained before imaging. Indiscriminate imaging may result in false positive findings such as disc bulges that are not actually the cause of the patient's pain. Relying solely on imaging studies to evaluate the source of low back pain carries a significant risk of diagnostic confusion because of the possibility of identifying a finding that was present before symptoms began, but which did not cause the symptoms. Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated (Not explicitly stated is the risk that these findings will lead to an unnecessary intervention such as surgery). MRI imaging is recommended when cauda equina, tumor, infection or fracture is strongly suspected and plain film radiographs are negative. The clinical findings in this case do not support the performance of a lumbosacral MRI. In the first place, it appears likely that the requested MRI has already been performed and that the requesting provider is unaware of it, since the records contain an MRI report dated 4/22/14. Since this MRI showed considerable regression of the relatively large disc protrusion at L5-S1, and since there is no documented subsequent red flag or plan for surgery, another MRI is not medically indicated. Based on the MTUS citation above and the clinical documentation provided for my review, an MRI of the lumbar spine is not necessary in this case. It is not medically necessary the requested study appears to have already been performed and it contains no results that would require a follow-up MRI; and because the requesting provider has documented no findings or concerns for red flag conditions or of any plans for surgery.