

Case Number:	CM13-0066625		
Date Assigned:	01/03/2014	Date of Injury:	07/23/2010
Decision Date:	05/20/2015	UR Denial Date:	11/21/2013
Priority:	Standard	Application Received:	12/16/2013

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 51 year old male who was injured on 07/23/2010. He sustained an industrial injury to his lumbar spine while performing his duties as a forklift driver. He was lifting 2x4's. He felt a sharp burning sensation in his lower back radiating in his buttocks and down his left leg. Prior treatment history has included 6 sessions of physical therapy which was not helpful and traction therapy which was not helpful. The patient's medication history includes hydrocodone-acetaminophen; levothyroxine 75 mg; lisinopril 10 mg; simvastatin 20 mg; metformin 500 mg; and Tramadol HCL 50 mg. Diagnostic studies reviewed include MRI of the lumbar spine performed on 07/02/2012 revealed vertebral bodies appear of average height at the L4-L5 interspace. There is narrowing. The L1-L2 interspace shows no significant disc protrusion or stenosis. The L2-L3 interspace shows a left paracentral posterior disc protrusion which measures approximately 3.1 mm beyond the adjacent posterior vertebral body and margins. There is an effacement of the adjacent anterior thecal sac and left neural recess. The upper neural foramina appear preserved. The L3-L4 interspace shows congenital narrowing of the spinal canal and broad-based mild to moderately prominent posterior disc protrusion which measures approximately 4.0 mm beyond the adjacent posterior vertebral body margins. There is effacement of the adjacent anterior thecal sac bilateral facet arthropathy with encroachment upon the neural foramina. There is ligamentum flavum thickening with mild central stenosis. The signal change at the inferior adjacent plate of L3 is thought to be consistent with degenerative disc disease/prominent Schmorl's node. The L4-L5 interspace show no significant disc protrusion, however, there is thought to be congenital narrowing of the spinal canal with bilateral

facet arthropathy, greater to the right, with encroachment greater to the right as well. The L5-S1 interspace shows central posterior disc protrusion which measures approximately 3.6 mm beyond the adjacent posterior vertebral body margins. There is effacement of the adjacent anterior thecal sac with mild bilateral facet arthropathy, greater to the right. The impression is features of degenerative disc disease at L2-L3, L3-L4, L4-L5 and L5-S1. EMG/NCS performed 02/18/2013 revealed mixed neuropathy most likely diabetic (axonal and demyelinating); prolonged bilateral H-reflex is not a specific finding and maybe secondary to metabolic disorders (DM) vs. previous low back surgery vs. S1 radiculopathy; mild chronic left L5 radiculopathy. Additional Consultations include a consult with [REDACTED] and he was informed he needed a decompression surgery. Sometime in November of 2011, surgery was performed to his lumbar spine. He followed up with [REDACTED] on a month to month basis who took over his primary care. The patient states he got worse with time. He was informed by [REDACTED], he could undergo another surgery but it would be a huge risk. Clinic note dated 09/17/2013 documented the patient to have complaints of lumbar spine pain at a 8/10 scale of 1 to 10 with 1 being the lowest level pain and 10 being the maximum level of pain, described as a constant pain radiating to his thoracic spine; buttocks; left leg and left hip associated throbbing; stabbing; aching; sharp; electric-like sensations; numbness; tingling; and cramping in his lumbar spine. He has limited range of motion with prolonged carrying; lifting, pushing; pulling; bending; squatting; kneeling; walking; standing; and sitting which increases the pain in his lumbar spine. The patient was examined with x-rays of the lumbar spine. The outcome of his x-rays was normal with no fractures or dislocations. His range of motion revealed lumbar flexion is limited to 18 inches from the floor with the fingertips, extension is 18 degrees, left lateral bending is 17 degrees, right lateral bending is 15 degrees, left rotation is at 15 degrees and right rotation is at 14 degrees. His muscle testing reveals left-sided dorsiflexors have a grade 4 weakness to the foot and the left-sided extensor hallucis longus has a grade 4 weakness there as well; deep tendon reflexes are -1/4 in the L4 and S1 bilaterally. Kemp's test is positive in the lumbar spine; straight leg raise is positive on the left at 60 degrees. The patient was diagnosed with 1) Lumbar degenerative process and features of degenerative disc disease at L2-L3, L3-L4, L4-L5, and L5-S1 as described in the Physician's Imaging of Visalia MRI report dated July 2, 2012; 2) Lumbar radiculitis, clinically. Clinic note dated 10/29/2013 documented the patient to have complaints of pain in the lumbar spine at a level of 8-9/10. The activities that ring the pain on included excessive range of motion with flexion or extension; carrying; lifting; pushing; pulling; bending; squatting; kneeling; walking for prolonged periods of time; standing for prolonged periods of time or sitting for prolonged periods of time, all of which produce lumbar spine pain. He also has pain that radiates into his buttock, left leg, and left hip. The patient was diagnosed with lumbar spine radiculitis, clinically. Clinic note dated 05/30/2013 documented the patient to have complaints of low back pain radiating to both legs and occasional severe pain radiating down the left leg to the bottom of the foot. He states that he has not had any physical therapy for quite some time. Objective findings on exam revealed sensation is decreased in L4, L5, and S1 bilaterally; reflexes are absent in the knees and ankles bilaterally. The left calf appears to be slightly smaller than the right. The recommendation for this patient is not inclined to surgery at this time.

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 with 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 Low back chapter, MRI.

Decision rationale: The patient was injured on 07/23/2010 and presents with lumbar spine pain. The request is for MRI OF THE LUMBAR SINE WITH CONTRAST. There is no RFA provided and the patient is to return to work on 10/30/2013 with the following restrictions: No excessive walking or prolonged standing, no climbing of ladders/stairs, no excessive pushing/pulling/twisting, and no lifting over 25 pounds. The patient had a prior MRI of the lumbar spine on 07/02/2012 which revealed degenerative disk disease at L2-L3, L3-L4, L4-L5, and L5-S1. For special diagnostics, ACOEM Guidelines page 303 states, "Unequivocal and equivocal objective findings that identified specific nerve compromise on neurological examination or sufficient evidence to warrant imaging in patient who did not respond well to retreatment and who could consider surgery an option. Neurological examination is less clear; however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study." ODG Guidelines on low back chapter MRI topics states that "MRIs are tests of choice for patients with prior back surgery, but for uncomplicated low back with radiculopathy, not recommended until at least 1 month of conservative care, sooner if severe or progressive neurologic deficit." The reason for the request is not provided. In this case, the patient had a prior MRI of the lumbar spine on 07/02/2012. He is diagnosed with lumbar spine radiculitis and degenerative disk disease at L2-L3, L3-L4, L4-L5, and L5-S1. His lumbar spine pain radiates into his buttock, left leg, and left hip, and is associated with throbbing, stabbing, aching, and sharp leg pain. He has a limited lumbar spine range of motion, a positive Kemp's test. Review of the reports provided does not mention if the patient had a recent surgery or any recent therapy. In this case, there are no new injuries, no significant change on examination findings, no bowel/bladder symptoms, or new location of symptoms that would require additional investigation. Therefore, the requested repeat MRI of the lumbar spine IS NOT medically necessary.

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 based on Non-MTUS Citation Official disability guidelines Low back chapter, MRI.

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