

Case Number:	CM14-0112634		
Date Assigned:	09/16/2014	Date of Injury:	01/13/2001
Decision Date:	07/16/2015	UR Denial Date:	06/18/2014
Priority:	Standard	Application Received:	07/18/2014

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. 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: Emergency Medicine

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 55 year old male who sustained an industrial injury on 01/13/2001. Current diagnoses include status post circumferential fusion, L4-S1, urological diagnosis, and medial meniscus tear, right knee. Previous treatments included medication management and back surgery. Previous diagnostic studies include a lumbar spine MRI with contrast dated 04/24/2014. Report dated 04/15/2014 noted that the injured worker presented with complaints that included low back pain with radiation to the bilateral lower extremities with associated numbness and tingling. Noting that this has been worse over the last couple of weeks. Pain level was not included. Physical examination was positive for tenderness in the lower lumbar paravertebral musculature, decreased range of motion, and positive straight leg raise bilaterally. The treatment plan included requests for MRI of the lumbar spine with gadolinium due to increase of symptoms, transportation to and from all medical visits, administration of a Toradol injection, prescription refills for Voltaren and Norco. Disputed treatments include a MRI of the lumbar spine with gadolinium and Norco.

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 GADOLINIUM: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, Low Back (acute and chronic).

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

Decision rationale: The requested MRI OF THE LUMBAR SPINE WITH GADOLINIUM, is not medically necessary. CA MTUS, ACOEM 2nd Edition, 2004, Chapter 12, Lower Back Complaints, Special Studies and Diagnostic and Therapeutic Considerations, Pages 303-305, recommend imaging studies of the lumbar spine with "Unequivocal objective findings that identify specific nerve compromise on the neurological examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option." The injured worker has low back pain with radiation to the bilateral lower extremities with associated numbness and tingling. Noting that this has been worse over the last couple of weeks. Pain level was not included. Physical examination was positive for tenderness in the lower lumbar paravertebral musculature, decreased range of motion, and positive straight leg raise bilaterally. Even though the treating physician has noted an increase in the injured worker's symptoms, there is insufficient documentation of an acute change in physical exam findings indicative of nerve root compromise. The criteria noted above not having been met, MRI OF THE LUMBAR SPINE WITH GADOLINIUM is not medically necessary.

1 PRESCRIPTION OF NORCO 5/325 MG, # 30 WITH 2 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82.

Decision rationale: The requested 1 PRESCRIPTION OF NORCO 5/325 MG, # 30 WITH 2 REFILLS, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, recommend continued use of this opiate for the treatment of moderate to severe pain, with documented objective evidence of derived functional benefit, as well as documented opiate surveillance measures. The injured worker has low back pain with radiation to the bilateral lower extremities with associated numbness and tingling. Noting that this has been worse over the last couple of weeks. Pain level was not included. Physical examination was positive for tenderness in the lower lumbar paravertebral musculature, decreased range of motion, and positive straight leg raise bilaterally. The treating physician has not documented VAS pain quantification with and without medications, duration of treatment, objective evidence of derived functional benefit such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention, nor measures of opiate surveillance including an executed narcotic pain contract or urine drug screening. The criteria noted above not having been met, 1 PRESCRIPTION OF NORCO 5/325 MG, # 30 WITH 2 REFILLS is not medically necessary.

