

<b>Case Number:</b>	CM14-0204067		
<b>Date Assigned:</b>	12/16/2014	<b>Date of Injury:</b>	06/19/2013
<b>Decision Date:</b>	02/06/2015	<b>UR Denial Date:</b>	11/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/05/2014

### 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 Rehab, has a subspecialty in Pain 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 43 year old male was injured 6/19/13 when he was unloading a truck and his foot became stuck, he pushed and twisted his back resulting in acute, sharp low back pain radiating down both legs more on the left with numbness, tingling and weakness. On physical exam of the lower extremities there was pain over the left sciatic notch with spasms and pain in the lumbosacral area with restricted range of motion to about half. There was tenderness on palpation of the L3-S1 spinous process, left gluteus, lumbar paravertebral muscles and thorocolumbar junction. In addition there was diminished sensation in the lateral aspect of his legs and grossly positive straight leg raise by 40 degrees bilaterally with pain to feet. Pain intensity is 5-8/10. Lumbar spine MRI demonstrated L4-5 central canal and lateral recess stenosis due to loss of disc height and facet arthropathy. The latest MRI (9/28/13) demonstrated at L3-4 mild height loss; mild facet arthropathy and at L4-5 mild to moderate disc height loss; neural foramina are mild to moderate stenotic on the left but patent on the right. Since this MRI the orthopedic and neurologic findings have deteriorated. Diagnosis was bilateral lower extremity radiculopathy secondary to disc injury, possible instability; cervical sprain/ strain; lumbar disc protrusion; lumbar facet arthropathy; lumbar radiculopathy; displacement of lumbar disc without myelopathy; arthralgia of TMJ (from teeth grinding due to pain); gastritis and gastroduodenitis; fatigue; sleep disturbance and psych disorder. His medications include Tramadol, Tylenol #3 and cyclobenzaprine. He experienced continued restriction to his activities of daily living including sudden or repetitive movement, sitting, standing, walking, driving, bending, twisting, holding still, reaching, reaching, pushing, pulling repetitively and stooping and squatting. His objective findings have deteriorated and function is worse per documentation. Surgery has been recommended as he failed all other options (records did not indicate the failed options) and MRI demonstrated surgical lesion. The injured worker remains off work. A neurosurgical consultation

dated July 10, 2014 identifies diminished sensation at the L5 and S1 dermatomes bilaterally with normal motor strength. A progress report dated August 11, 2014 states that the patient's exam findings are worse, his ability to do activities of daily living is worse, and he is no longer working because he is medically worse. A progress report dated October 6, 2014 shows decreased strength in the left lower extremity. On 11/13/14 Utilization Review non-certified the request for Lumbar MRI based on no dramatic change in the injured workers complaints of pain. His neurological status has not deteriorated and there is no indication for a repeat MRI. There was documentation of a previous lumbar MRI (9/28/13) and there was no indication of a significant change in pathology. ODG was referenced.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Repeat lumbar MRI:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); repeat MRI's

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303 and 304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, MRIs (magnetic resonance imaging).

**Decision rationale:** Regarding the request for repeat lumbar MRI, Occupational Medicine Practice Guidelines state that 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 would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. ODG states that MRIs are recommended for uncomplicated low back pain with radiculopathy after at least one month of conservative therapy. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Within the documentation available for review, it appears the patient's subjective complaints are worse and there is new identification of weakness in the left lower extremity since the time of the last MRI. Furthermore, it appears that conservative treatment has failed and that surgical intervention is being considered and will be based upon the outcome of the currently requested MRI. As such, the currently requested a repeat lumbar MRI is medically necessary.