

Case Number:	CM14-0208851		
Date Assigned:	12/22/2014	Date of Injury:	07/24/1986
Decision Date:	02/18/2015	UR Denial Date:	11/04/2014
Priority:	Standard	Application Received:	12/12/2014

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: Internal 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 patient is an injured worker with a history of chronic low back complaints. Date of injury was July 24, 1986. Regarding the mechanism of injury, while the patient was at work swinging a hammer on a foundation and a wall fell on the patient. The patient had surgery of the cervical and lumbar spine. He had a lumbar endoscopic discectomy and thermal annuloplasty at L4-5 performed on August 18, 2005. MRI magnetic resonance imaging of the lumbar spine dated January 31, 2014 demonstrated moderate broad-based central and right paramedian disc protrusion at L5-S1. Mild to moderate right foraminal narrowing. Multilevel degenerative change was noted. The alignment is within satisfactory limits. The lumbar vertebral bodies are normal in height. The conus appears within satisfactory limits. The paraspinous soft tissues appear unremarkable. L1-2 was negative. L2-3 was negative. L3-4 demonstrated disc desiccation is present. Mild disc bulge is noted. Mild degenerative change of the facet joints is demonstrated. Foraminal narrowing is not identified. L4-5 demonstrated disc degeneration is demonstrated. Degenerative change of the facet joints is noted. Disc extrusion is not identified. Foraminal narrowing is not identified. L5-S1 demonstrated degenerative change of the facet joints is demonstrated. Disc desiccation is noted. A broad-based central and right paramedian disc protrusion is noted. Mild to moderate right foraminal narrowing is present. The progress report dated October 27, 2014 documented that the patient presented for follow-up of chronic pain. The condition from which the patient suffered was chronic low back pain and chronic neck pain. The average pain over the past week was 7/10. The worst pain this past week was 9/10. The current pain relief made a real difference for the patient. The patient denies common side effects

such as nausea, vomiting, constipation, and itching. Patient brought 154 units of the long acting opiate and 36 units of the short acting opiate. There was discomfort most prominent in the cervical spine and in the lumbar spine. This radiated to the right buttock, posterior thighs, and right calf. The patient characterized it as constant, severe, sharp, throbbing, and aching pain. This was a chronic problem, with essentially constant pain. The patient stated that the current episode of pain started 5 weeks ago. The patient did not recall any precipitating event or injury. Aggravating factors which contributed to the back pain was lifting, bending-over, twisting, throwing, pushing a heavy object, and pulling a load. Associated symptoms included stiffness, paravertebral muscle spasm, and radicular right leg pain. The patient denied fever, unexplained weight loss, and numbness in the legs or paresthesias. The patient had not found anything that helped relieve the pain. The pain worsened with walking, back flexion, back extension, twisting movements, hip flexion, hip extension, and hip rotation. Physical examination of the lumbar spine revealed normal skin, soft tissue, and bony appearance with gentle lumbar lordotic curve and no gross edema or evidence of acute injury. There was right sacroiliac area but only with deep palpation tenderness. Muscle strength was 5/5 in the left and right tibialis anterior and 4/5 in the left and right extensor hallucis longus. Active range of motion revealed extension, right lateral flexion, and pain with posterior loading. There was positive right straight leg raise. The treatment plan included prescriptions for Methadone, Methylphenidate, and Hydrocodone/Acetaminophen and prescription of Duloxetine and Prednisone.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of lumbar spine with and without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG Low Back (updated 10/28/14), MRIs (Magnetic Resonance imaging)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304, 308-310.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses magnetic resonance imaging MRI of the lumbosacral spine. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints states that relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false-positive test results). Table 12-8 Summary of Recommendations for Evaluating and Managing Low Back Complaints (Page 308-310) recommends MRI when cauda equina, tumor, infection, or fracture are strongly suspected and plain film radiographs are negative. The medical records document that lumbar endoscopic discectomy and thermal annuloplasty at L4-5 was performed on August 18, 2005. MRI magnetic resonance imaging of the lumbar spine dated January 31, 2014 demonstrated moderate broad-based central and right paramedian disc protrusion at L5-S1. Mild to moderate right foraminal narrowing. Multilevel degenerative change was noted. The progress report dated October 27, 2014 documented that the patient did not recall any precipitating event or injury. Plain film radiographs were not documented. No evidence of cauda equina, tumor, infection, or fracture

was documented. The 11/27/14 physical examination did not demonstrate evidence of significant acute pathology. The request for lumbar MRI magnetic resonance imaging is not supported by the medical records and MTUS guidelines. Therefore, the request for MRI of lumbar spine with and without contrast is not medically necessary.