

<b>Case Number:</b>	CM15-0110944		
<b>Date Assigned:</b>	06/17/2015	<b>Date of Injury:</b>	09/29/1993
<b>Decision Date:</b>	07/22/2015	<b>UR Denial Date:</b>	06/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2015

### 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: Texas, California  
 Certification(s)/Specialty: Family Practice

### 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 48-year-old female, who sustained an industrial injury on 09/29/1993. She has reported subsequent low back and head pain and was diagnosed with lumbar degenerative disc disease, lumbar facet arthropathy, lumbar spinal stenosis, RSD of the upper and lower limb and migraine headaches. Treatment to date has included medication, Botox injections, H-wave unit and spinal cord stimulator. In a progress note dated 04/17/2015, the injured worker reported that Botox injections had helped with migraine headaches. Head pain was rated as 7/10 and low back and knee pain was rated at 4-5/10. Objective findings were notable for tenderness of the lumbar spine, swelling in the bilateral lower extremities, hyperpigmentation with color changes from ankle to knee and positive bilateral tenderness and scaling. The patient has had a normal steady gait. A recent detailed physical and neurological examination of the low back was not specified in the records provided. A request for authorization of MRI of the lumbar spine with and without contrast was submitted. There was no documentation submitted that pertains to the current treatment request. Per note dated 5/21/15, patient had complaints of numbness in thoracic spine with arm weakness. The patient has used an intrathecal drug delivery system. The medication list include Zofran, Nuvigil, Lasix, Maxalt, Imitrex and Omeprazole. Patient has received an unspecified number of PT visits for this injury. The records submitted contain no accompanying current PT evaluation for this patient.

### 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 and without contrast: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

**Decision rationale:** Per the ACOEM, low back guidelines cited below "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 who 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. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures). "Patient did not have any evidence of severe or progressive neurologic deficits that are specified in the records provided. Any finding indicating red flag pathologies were not specified in the records provided. The history or physical exam findings did not indicate pathology including cancer, infection, or other red flags. The patient has had normal steady gait. A recent detailed physical and neurological examination of the low back was not specified in the records provided. Patient has received an unspecified number of PT visits for this injury. The records submitted contain no accompanying current PT evaluation for this patient. A detailed response to complete course of conservative therapy including PT visits was not specified in the records provided. Previous PT visit notes were not specified in the records provided. A plan for an invasive procedure of the lumbar spine was not specified in the records provided. In addition, it is noted in the records that the patient's pain was relieved with conservative therapy. A recent lumbar spine X-ray report is not specified in the records provided. MRI of the lumbar spine with and without contrast is not medically necessary for this patient.