

Case Number:	CM14-0179176		
Date Assigned:	11/03/2014	Date of Injury:	10/07/2012
Decision Date:	12/12/2014	UR Denial Date:	10/22/2014
Priority:	Standard	Application Received:	10/28/2014

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 Neurology, has a subspecialty in Clinical Neurophysiology and is licensed to practice in Virginia. 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:

According to the records made available for review, the injured worker is a 35 year old with a date of injury of 07 October, 2012. The mechanism of injury is not stated in the medical records. At the time of the request for review, there is a clinical note dated 27 October, 2014 in which the injured worker has a subjective complaint of lumber spine pain. The pain intensity is 9/10 and there is a complaint of bladder incontinence. The physical exam at the time of this exam does not elaborate on any Neurologic exam with specific Neurologic findings. There is an EMG/NCV test performed on 08 July, 2014. The needle study showed increased insertional activity in the right and left Tibialis Anterior and right Vastus Medialis muscles. There is no paraspinal muscle testing documented in this study. The impression of the study is an acute on chronic L4 greater than L5 radiculopathy on the right. There is a Lumbar myelogram documented in the records dated 10 January, 2014. This showed a mild to moderate disk herniation at the L2-3 level with no significant central canal stenosis. There is mild disk bulging documented on this study at the L3-4 and L4-5 disk levels. There is no foraminal stenosis at the L3-4 level. There is a 3 mm bulging disk eccentric to the left and abutting the L5 nerve root. There is a small disk bulge at the L5-S1 disk space which does not compress the thecal sac and with minimal compression of the L5 and S1 nerve roots. There is an MRI L spine documented in the medical record dated 09 October, 2012 which showed only multilevel degenerative disease. There are several clinical notes documented in the medical record with different findings on exam. There is an Orthopedic evaluation dated 29 July, 2014 which documented a 1/10 pain intensity with no specific documented findings on exam but with documentation of a positive straight leg test on the right and with dysesthesias noted on the right in an L4, L5 and S1 dermatomal levels. There is a clinical note in the record dated 06 May, 2014 which documents a 9/10 pain intensity in the

lumbar spine radiating down the right leg to the heel but with normal strength testing on clinical exam.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI left pelvis & second opinion neurosurgeon eval & treatment: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304-305.

Decision rationale: MTUS documentation states that relying on imaging studies to evaluate a source of low back pain and related symptoms carries a significant risk of diagnostic confusion. There is an overall 30% false positive rate for imaging studies in patients over age 30 who have findings on imaging but who do not have clinical symptoms. The presence of a herniated disk on an imaging study does not necessarily imply nerve root dysfunction. In the case of the injured worker, there is evidence of pathology in the lumbar spine in the medical record. The lumbar myelogram documents an eccentric 3 mm disk abutting the left L5 nerve root but the clinical exam only documents dysesthesias in the right leg. There is variability in the exams documented in the medical record of the injured worker. The injured workers EMG report documents muscle membrane instability in the right Tibialis Anterior and Vastus Medialis but documents no further evidence to confirm electrophysiologic evidence of a radiculopathy. There is no clear mention of a treatment plan in the medical record that discusses potential conservative therapies tried in this case or is there a treatment plan that discusses the potential benefits that an MRI pelvis may show. Therefore, based on the guidelines and on the review of the evidence, an MRI of the left pelvis is not medically necessary. MTUS guidelines states that referral for a surgical consult is indicated in patients who have severe symptoms in the legs in a distribution consistent with abnormalities on imaging studies and preferably with objective accompanying signs of neural compromise. In the case discussed above, there are no clear objective signs or symptoms of a radiculopathy on clinical exam. As stated above, the presence of a disk on an imaging study does not in and of itself imply a specific nerve root dysfunction clinically. Therefore, based on the guidelines and the review of the evidence, the request for a second Neurosurgical opinion for an evaluation and treatment is not medically necessary.