

<b>Case Number:</b>	CM14-0176795		
<b>Date Assigned:</b>	10/30/2014	<b>Date of Injury:</b>	06/15/2013
<b>Decision Date:</b>	04/22/2015	<b>UR Denial Date:</b>	09/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/24/2014

### 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: North Carolina

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 54-year-old, female, who sustained a work related injury on 6/15/13. The diagnoses have included lumbar radiculopathy and lumbar strain. Treatments have included EMG/NCV of lower extremities on 10/6/14, medications, physical therapy, MRI lumbar spine 8/7/13, lumbar epidural steroid injection, modified work duty and home exercise program. In the Panel Qualified Medical Evaluation dated 9/24/14, she complains of lower back pain. She walks with a slight antalgic gait favoring left leg. She has spasm and guarding at base of spine. She has a positive left straight leg raise. Lumbar spine range of motion is restricted. The treatment plan is a recommendation of lumbar surgery. The requested treatment for this Independent Medical review of an MRI of lumbar spine is not noted.

### 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 without contrast:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter ,and MRI.

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

**Decision rationale:** The ACOEM chapter on low back complaints and special diagnostic studies states: 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). 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) because of the possibility of identifying a finding that was present before symptoms began and therefore has no temporal association with the symptoms. Techniques vary in their abilities to define abnormalities (Table 12-7). Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Because the overall false-positive rate is 30% for imaging studies in patients over age 30 who do not have symptoms, the risk of diagnostic confusion is great. There is no recorded presence of emerging red flags on the physical exam. The patient had a previous MRI in 7/2013. There is no significant change in symptoms or exam. Therefore, the request does not meet criteria per the ACOEM for repeat MRI and is denied. Therefore, this is not medically necessary.