

<b>Case Number:</b>	CM14-0181682		
<b>Date Assigned:</b>	11/06/2014	<b>Date of Injury:</b>	09/18/2012
<b>Decision Date:</b>	08/03/2015	<b>UR Denial Date:</b>	10/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/31/2014

### 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 52 year old male, who sustained an industrial injury on 09/18/2012. He has reported injury to the low back, right shoulder, and bilateral hands. The diagnoses have included lumbar spine disc herniation with right lower extremity radicular pain; bilateral hand pain, essentially resolved; and right shoulder rotator cuff syndrome, rule out tear. Treatment to date has included medications, diagnostics, lumbar epidural steroid injection, TENS (transcutaneous electrical nerve stimulation) unit, physical therapy, and home exercise program. Medications have included Ultram and Kera-Tek Gel. A progress note from the treating physician, dated 10/06/2014, documented a follow-up visit with the injured worker. Currently, the injured worker complains of persistent pain in the lumbar spine and the right hand; the pain is rated at 4/10 on a pain scale; the pain is constant and unchanged since the last visit; he continues to have radiation of pain from the lumbar spine into the right lower extremity; the pain is made better with medication, lumbar epidural steroid injection, and with TENS unit; the Ultram helps his pain from a 4 down to a 1 or 2; the pain is made worse with activities and bending; and he is not currently working. Objective findings included tenderness to palpation bilaterally over the lumbar paraspinal muscles, worse on the right than on the left; limited range of motion with rotation on the right due to pain; right shoulder tenderness to palpation; limited range of motion with abduction and external rotation; strength was 4/5; and Hawkins test was positive. The treatment plan has included the request for an MRI of the lumbar spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**An MRI of the lumbar spine:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**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 evidence of nerve compromise on physical exam with failure of conservative therapy. For these reasons, criteria for imaging as defined above per the ACOEM have been met. Therefore the request is medically necessary.