

<b>Case Number:</b>	CM15-0108355		
<b>Date Assigned:</b>	06/15/2015	<b>Date of Injury:</b>	12/07/2009
<b>Decision Date:</b>	07/14/2015	<b>UR Denial Date:</b>	05/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2015

### 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: 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 60 year old male, who sustained an industrial injury on 12/07/2009. He has reported injury to the low back. The diagnoses have included chronic back pain; lumbar disc disease; facet joint dysfunction; sacroiliac joint dysfunction; synovial cyst; L5 nerve root irritation; myofascial pain; and chronic left foot pain. Treatment to date has included medications, diagnostics, injections, acupuncture, chiropractic therapy, and physical therapy. Medications have included Norco and Naproxen. A progress note from the treating physician, dated 04/21/2015, documented a follow-up visit with the injured worker. The injured worker reported significant lower back problems; pain is bilateral, worse on the left side currently; fairly severe pain rated at 7/10 on the visual analog scale; the pain causes him to feel nauseated; he gets significant pain relief with the use of Norco and Naproxen; both legs have radiating pain; in the right leg, the pain goes down to the medial and lateral thigh and lateral calf, and likewise in the left leg to the lateral calf. Objective findings included weight loss; lumbar spine range of motion is restricted especially with flexion and extension; there is tenderness over both sacroiliac joints; tests for sacroiliac joint dysfunction are positive on both sides; reflexes are reduced at the right patella, trace, compared to 1+ on the left; Achilles reflexes are absent bilaterally; he is able to stand on his heels and toes although he has some difficulty; and the injured worker is now complaining of sacroiliac joint generated pain, and there are objective findings to support sacroiliac joint generated pain. The treatment plan has included the request for repeat MRI (magnetic resonance imaging) of lumbar spine.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Repeat MRI of Lumbar Spine:** 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).

**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. There is evidence of nerve compromise on physical exam but there is not mention of consideration for surgery or complete failure of conservative therapy. For these reasons, criteria for imaging as defined above per the ACOEM have not been met. Therefore the request is not medically necessary.