

Case Number:	CM15-0136322		
Date Assigned:	07/24/2015	Date of Injury:	11/10/2003
Decision Date:	08/20/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	07/14/2015

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 47-year-old male, who sustained an industrial injury on November 10, 2003. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having lumbar disc disease, lumbar radiculopathy, lumbar facet syndrome, left sacroiliac joint arthropathy, left piriformis syndrome, and chronic pain. Treatment and diagnostic studies to date has included laboratory studies, magnetic resonance imaging of the lumbar spine, home exercise program, medication regimen, and use of a cane. In a progress note dated May 14, 2015 the treating physician reports complaints of pain to the lumbar spine. Examination reveals an antalgic gait to the left, difficulty with heel and toe walk to the right along with being unable to heel to walk on the left, moderate to severe tenderness to the thoracolumbar paraspinal muscles to the left buttock, moderate facet tenderness at lumbar four through sacral one, positive left piriformis stress test and tenderness, positive left sacroiliac tenderness, positive left sacroiliac thrust test, positive left Yoeman's test, positive left Lasegue test, positive bilateral Kemp's test, positive left straight leg raise, positive bilateral Valsalva maneuver, decreased range of motion to the lumbar spine, decreased sensation to lumbar four through sacral one dermatomes on the left, and decreased strength to the left knee extensors, hip flexors, and big toe extensors. The injured worker's pain level was rated a 5 out of 10. The treating physician requested magnetic resonance imaging of the lumbar spine with the treating physician noting that the injured worker's symptoms have progressively worsened and that the injured worker's symptoms have increased since the injured worker's last magnetic resonance imaging in 2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

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), 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. 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.