

Case Number:	CM15-0162153		
Date Assigned:	08/28/2015	Date of Injury:	11/29/2012
Decision Date:	09/30/2015	UR Denial Date:	08/14/2015
Priority:	Standard	Application Received:	08/18/2015

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 11-29-12. His initial complaint was of pain in his back. His injury was sustained while moving a table during working hours. He developed "severe left lower extremity pain" following the injury. The 1-8-13 orthopedic report indicates that he "has mild right-sided pain, but most of his issues are on the left-hand side". He received physical therapy with no effect noted. His diagnoses included lumbago and lumbar radiculopathy. The treatment plan was a prescription of Tramadol due to the injured worker "writhing in pain". The provider also stated consideration for a transforaminal epidural steroid injection at L4-L5, left side, through pain management or decompression off to the left-hand side L4-L5. The document states, "Ultimately, the decompression should be over the injection because the injection may be temporary and the cyst is not really going to go away with just one injection". In April 2015, an orthopedic-legal evaluator examined the injured worker. The report states, "There is a question of getting a repeat MRI because of persistent pain and also weakness. At this time, it is not unreasonable to obtain a repeat MRI as a baseline in case he needs a fusion in the future". The orthopedic consultation report, dated 8-12-15, indicates that he has undergone chiropractic and acupuncture treatment "before a surgery". It states that he underwent a surgery of his lumbar spine and "did not really get better". He underwent physical therapy, then, had a second surgery in May 2013. The report indicates that the injured worker does not feel that surgery has helped him. Treatment recommendations were noted to be for a revision surgery, as well as a new decompression at L4-5. The report states "we

have, yet, to hear back regarding any response to surgery" and "this is quite concerning, as the injured worker's legs are becoming progressively more weak". His diagnoses included post-laminectomy syndrome, cervicgia, lumbosacral neuritis, lumbago, spinal stenosis, lumbar spine without claudication, sciatica, and joint pain - shoulder. A repeat MRI of the lumbar spine was recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of lumbar with and without contrast: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Lower Back (Acute & Chronic).

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 inpatients 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. The criteria for imaging as cited above have been met in the provided medical records for review. Therefore the request is medically necessary.