

<b>Case Number:</b>	CM15-0169026		
<b>Date Assigned:</b>	09/09/2015	<b>Date of Injury:</b>	11/15/2013
<b>Decision Date:</b>	10/07/2015	<b>UR Denial Date:</b>	08/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/27/2015

### 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 50-year-old female who sustained an industrial injury on 11-15-13. Diagnoses are sprain-strain lumbar region, pain in joint lower leg and history of diabetes and hypertension. Previous treatment includes an MRI of the lumbar spine without contrast 10-8-14, medications, at least 12 sessions of physical therapy, acupuncture, and chiropractic treatment. It is noted that a lumbar epidural steroid injection has been requested previously and if it is not approved, she will be placed for surgical consultation or will consider re-requesting. In a visit note dated 8-5-15, the treating physician reports subjective complaints of left knee pain, left shoulder pain, and lower back pain. Left knee pain is worse with ambulation. She has an antalgic gait, utilizes a cane for ambulation, and was scheduled for arthroscopic surgery, which was canceled due to high blood glucose levels. She continues to have back pain with radiation into the left lower extremity, worse with activity or ambulation. There is lumbar spine spasm and guarding noted. Sensation to light touch is decreased along the lateral portion of the left lower extremity. Work status is that she is precluded from her usual and customary work is on modified work duty and if that is not available, she would be on total temporary disability. Tramadol ER is reported to provide approximately 20% pain relief and allows her to sleep through the night. She continues on Nabumetone, Protonix, and Gabapentin. The MRI of the lumbar spine without contrast done 10-8-14, reveals an impression of degenerative disc disease and facet arthropathy with transitional anatomy and with retrolisthesis L5-S1, canal stenosis includes L3-L4 mild, L4-L5 mild, L5-S1 mild canal stenosis with L5-S1 central right paracentral protrusion and annular fissure slightly contacting the right S1 nerve root, neural foraminal narrowing includes L4-L5 caudal left, mild to moderate right, and L5-S1 mild to moderate bilateral neural foraminal narrowing. An MRI of the lumbar spine was not approved on 8-11-15.

## **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:** 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.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

**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.