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| <b>Case Number:</b>   | CM15-0189938 |                              |            |
| <b>Date Assigned:</b> | 10/02/2015   | <b>Date of Injury:</b>       | 02/15/2010 |
| <b>Decision Date:</b> | 11/09/2015   | <b>UR Denial Date:</b>       | 09/14/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 09/28/2015 |

### 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:

This 61 year old male sustained an industrial injury on 2-15-10. Documentation indicated that the injured worker was receiving treatment for lumbar spondylolisthesis and disc herniation with facet arthropathy. The injured worker underwent lumbar fusion at L3-5 on 3-19-15. The injured worker received postoperative physical therapy and medications. In a PR-2 dated 4-22-15, the injured worker complained of ongoing numbness and pain in the right leg extending to the foot. The injured worker had difficulty standing or sitting for more than 5 to 10 minutes without significant pain. In a PR-2 dated 6-9-15, the injured worker complained of back and right leg pain. The injured worker felt that the leg pain had improved with Neurontin and that the pain he was having prior to surgery had improved. In July and August 2015 physical therapy progress notes, the injured worker consistently rated his pain 10 out of 10 on the visual analog scale. In a Pr-2 dated 8-24-15, the injured worker complained of back and right leg pain. The injured worker stated that he was having difficulty with day to day activities due to pain. The injured worker stated that he did not feel that Neurontin had been very effective for him. Physical exam was remarkable for "breakthrough" pain on exam of the right lower extremity, 5 out of 5 lower extremity strength with the exception of 4+ out of 5 right big toe extension. The injured worker walked with an antalgic gait and had difficulty changing positions from sitting to standing. X-rays taken during the office visit showed the hardware in good position. The treatment plan included prescriptions for Neurontin, Norco and Flexeril, continuing physical therapy and magnetic resonance imaging lumbar spine due to persistent right leg pain postoperatively. On 9-

10-15, Utilization Review noncertified a request for magnetic resonance imaging lumbar spine with and without contrast.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **MRI with and without Contrast (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 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.