

Case Number:	CM15-0192220		
Date Assigned:	10/06/2015	Date of Injury:	09/05/2012
Decision Date:	11/12/2015	UR Denial Date:	09/15/2015
Priority:	Standard	Application Received:	09/30/2015

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 44 year old male who sustained an industrial injury on 09-05-2012. According to a progress report dated 09-01-2015, the injured worker was seen for back pain radiating from the low back down both legs. Pain level had increased since the last visit. With medications, pain was rated 4 on a scale of 1-10. Without medications, pain was rated 7.5. He also reported numbness, tingling and weakness. Quality of sleep was poor. Activity level had decreased. Back pain continued to get worse. He had shooting pain down both legs that was described as "electrical" in nature. His intolerance for activity continued to worsen. He was tripping frequently. His legs were weak and felt heavy. He could only walk very short distances and then had to rest. Current medications included Lyrica, Norco and Omeprazole. MRI of the lumbar spine performed on 10-25-2015 showed L4-L5 10 millimeter central canal stenosis due to 5 millimeter posterocentral disc protrusion and annular fissure, mild bilateral neural foraminal stenosis due to disc bulge, L5-S1 10 millimeter central canal stenosis due to 8 millimeter posterocentral and paracentral disc protrusion. There was indentation on bilateral S1 traversing nerve root and moderate bilateral neural foraminal stenosis due to disc bulge and facet arthrosis. Motor testing was limited by pain. Motor strength of ankle dorsi flexors was 4 plus out of 5 on both sides. Ankle planter flexor was 4 plus out of 5 on both sides. All the muscles of the body appeared normal and had normal tone. There was no hypotonia or hypertonia. Light touch sensation was decreased over lateral calf on both sides. Deep tendon reflex knee jerk was 2 out of 4 on both sides. Ankle jerk was 1 out of 4 on both sides. Diagnoses included low back pain, lumbar radiculopathy, disc disorder lumbar, post lumbar

laminectomy syndrome and abdominal pain. The treatment plan included appeal denial of MRI of the lumbar spine due to increased back pain and sharp shooting pain down the back of legs that was electrical in nature with numbness and weakness. Prescriptions included Percocet, Lyrica and Omeprazole. Work status was noted as permanent and stationary. An authorization request dated 09-08-2015 was submitted for review. The requested services included MRI of the lumbar spine. On 09-15-2015, Utilization Review non-certified the request for MRI of the lumbar spine.

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: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back-Lumbar and Thoracic (Acute and Chronic) Section: MRIs (Magnetic Resonance Imaging).

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 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 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.