

Case Number:	CM15-0207788		
Date Assigned:	10/26/2015	Date of Injury:	07/17/2012
Decision Date:	12/07/2015	UR Denial Date:	10/07/2015
Priority:	Standard	Application Received:	10/22/2015

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 34 year old male sustained an industrial injury on 7-17-12. Documentation indicated that the injured worker was receiving treatment for lumbar post laminectomy syndrome. Previous treatment included bilateral microforaminotomy at L4-5 and bilateral microdiscectomy at L5-S1 (2-26-14), injections, physical therapy and medications. In a spine clinic follow-up note dated 8-24-15, the injured worker complained of ongoing low back pain, similar to his preoperative pain. The injured worker reported ongoing popping and grinding noises in his back accompanied by sharp shooting pain in his legs as well as numbness in bilateral thighs and occasional radiation of pain down to the right heel. The injured worker rated his pain 7 out of 10 on the visual analog scale. Physical exam was remarkable for intact sensation throughout bilateral lower extremities with 2+ deep tendon reflexes at bilateral patellae and Achilles and absent bilateral plantar flexor response. The physician documented that magnetic resonance imaging lumbar spine (10-20-14) showed disc bulge at L5-S1 displacing bilateral S1 nerve roots and arachnoiditis at L4-5 with facet arthropathy and stenosis. The physician recommended nonsurgical treatment at this time. In a progress note dated 9-29-15, the injured worker complained of ongoing low back pain. The injured worker stated that he felt that at times his legs "didn't function". The injured worker had begun participation in a functional restoration program. Physical exam was remarkable for tenderness to palpation across the lumbosacral junction, "limited flexion and extension, 5 out of 5 lower extremity strength, intact lower extremity sensation and negative straight leg raise. The physician recommended magnetic resonance imaging and x-rays of the lumbar spine due to popping in the low back on bending and given that previous studies were a year old. On 10-7-15,

Utilization Review noncertified a request for magnetic resonance imaging with or without GAD lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI with / without GAD Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic), MRIs.

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.