

Case Number:	CM15-0208765		
Date Assigned:	10/28/2015	Date of Injury:	10/03/1996
Decision Date:	12/08/2015	UR Denial Date:	10/22/2015
Priority:	Standard	Application Received:	10/23/2015

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 52 year old male with a date of injury on 10-03-1996. The injured worker is undergoing treatment for 13 years status post L5-S1 interbody fusion with transitional degenerative spondylosis L4-L5 with spinal stenosis, foraminal narrowing and neurogenic claudication with intermittent right L4 radiculitis. A physician progress note dated 10-12-2015 documents the injured worker has continued severe bilateral buttock, posterior thigh and calf pain with prolonged sitting, inactivity, stationary standing or walking more than several blocks. He follows with pain management. He had a Transforaminal Epidural Steroidal Injection in March of 2014 and it provided him with several months of pain relief. He has intermittent tingling of the medial aspect of both ankles. On examination, his radicular symptoms are reproduced with extreme active lumbar extension greater than 20 degrees. He has decreased sensation of the right L4 dermatome. There is documentation that plain X rays show an L5-S1 interbody fusion with titanium cage filled with iliac crest bone graft and there was narrowing of the L4-L5 disc space. A February 12, 2014 computed tomography scan shows spinal stenosis at L4-5 with bilateral foraminal narrowing. A 09-07-2010 lumbar Magnetic Resonance Imaging shows central spinal canal stenosis at L4-L5. Current medications include Percocet. On 10-22-2015 Utilization Review non-certified the request for MRI of the Lumbar Spine (Lower Back), with and without contrast, as an outpatient.

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 (Lower Back), With and Without Contrast, as an Outpatient:
Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

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.