

<b>Case Number:</b>	CM15-0213711		
<b>Date Assigned:</b>	11/03/2015	<b>Date of Injury:</b>	11/26/2014
<b>Decision Date:</b>	12/16/2015	<b>UR Denial Date:</b>	10/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/30/2015

### 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 59 year old female, who sustained an industrial injury on 11-26-2014. A review of the medical records indicates that the injured worker is undergoing treatment for L1 compression fracture status posttraumatic fall 11-26-2014 and isthmic L5-S1 grade 1 spondylolisthesis. On 9-24-2015, the injured worker reported axial low back pain. The Primary Treating Physician's report dated 9-24-2015, noted the injured worker with a guarded gait and significant pain on palpation of the upper lumbar spine over the spinous processes and paraspinal muscles. Prior treatments have included a MRI of the lumbar spine on 12-30-2014 with impression of recent compression fracture of L1 with 30% height loss, 8mm of retropulsion causing moderate narrowing of the central canal and bilateral L5 pars intra-articularis defects with mild anterolisthesis of L5 on S1 with corresponding mild narrowing of both neural foramina, physical therapy, right wrist surgery and removal of hardware, and bracing. The treatment plan was noted to include upright x-rays of the lumbar spine 5 views to assess change in vertebral height and alignment when standing, and a MRI of the lumbar spine with STIR images to assess for bony non-healing and consideration of serial selective injections for diagnostic and therapeutic purposes. The injured worker's work status was noted to be temporarily totally disabled. The request for authorization was noted to have requested lumbar spine x-rays 5 views and a MRI of the lumbar spine without contrast with STIR images. The Utilization Review (UR) dated 10-7-2015, certified the request for lumbar spine x-rays 5 views and non-certified the request for a MRI of the lumbar spine without contrast with STIR images.

## 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 without contrast, with STIR images:** Upheld

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

**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.