

<b>Case Number:</b>	CM15-0216572		
<b>Date Assigned:</b>	11/06/2015	<b>Date of Injury:</b>	09/30/2008
<b>Decision Date:</b>	12/21/2015	<b>UR Denial Date:</b>	10/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/03/2015

### 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 48 year old male with a date of injury on 09-30-2008. The injured worker is undergoing treatment for chronic lumbar radiculopathy. A physician progress note dated 10-01-2015 documents the injured worker complains of left shoulder pain after a fall, and a Magnetic Resonance Imaging was done and it showed a rotator cuff tear and he need surgery. On 05-01-2015 he received bilateral L5-S1 epidural injections and as of 10-01-2015 and now the pain is returning, he has a needle like pain in his left instep. He states he was using less medication and he could walk longer but he still has some limitations from his knees. He has right knee pain. He has complaints of a constant aching pain in the low back over the sacrum with radiation to the back of the left calf. He has numbness and tingling in his left leg. He has the same symptoms in his right leg but to a lesser extent. He occasionally has lumbar spasms. He rates his pain as 4 out of 10 and at its worst 8-9 out of 10 and at its best his pain is 4 out of 10. He has continued right and left shoulder pain. His back is painful to palpation in the lumbosacral junction and diffusely in the lower back. Spasm was present in the lower lumbar paravertebral muscle bilaterally. Sensation was decreased to light touch in the posterolateral aspect of both lower extremities. He also has sleep disturbance, anxiety and depression. There is documentation he had a lumbar Magnetic Resonance Imaging done on 07-03-2014 but reports were not present in documentation submitted for review. Treatment to date has included diagnostic studies, medications, and physical therapy, use of crutches, and status post lumbar laminectomy on 01-11-2001, L5-S1 transforaminal epidural steroid injection on 05-11-2015 with continued 50% relief on 10-01-2015, status post knee surgery and shoulder surgery. Current

medications include Norco, Omeprazole, Methadone, Triamterene, Fish oil, and Garlic oral, Cinnamon Bark, Wellbutrin, Ibuprofen, Buspar, and Maxzide. On 07-05-2015 his urine drug screen was consistent with his medications. On 10-15-2015 Utilization Review non-certified the request for a Magnetic Resonance Imaging 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 (magnetic resonance imaging), 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 & Thoracic (Acute & Chronic) - Magnetic resonance imaging (MRI).

**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.