

Case Number:	CM15-0089165		
Date Assigned:	05/13/2015	Date of Injury:	07/03/2006
Decision Date:	06/18/2015	UR Denial Date:	04/28/2015
Priority:	Standard	Application Received:	05/08/2015

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 56 year old male, who sustained an industrial injury on July 3, 2006. The injured worker was diagnosed as having degenerative disc disease and a disc bulge of the lumbar spine at L5-S1 plus facet spondylosis at L4-L5 and L5-S1 associated with bilateral lower extremity radiculitis, right knee medial meniscus tear plus a lateral meniscus tear with arthritis and probable synovitis, left knee arthritis and probable synovitis, and chronic pain syndrome associated with hypertension. Treatment to date has included MRIs, bracing, lumbar spine injections, and medication. Currently, the injured worker complains of constant lower back pain with radiation of pain down both of his legs with right leg greater than left leg pain, constant right hip pain, constant bilateral knee pain, with right knee symptoms greater than left knee symptoms. The Primary Treating Physician's report dated April 13, 2015, noted the injured worker had undergone the authorized lumbar spine MRI and bilateral knee MRIs requested for authorization on February 23, 2015. The injured worker was noted to currently not taking any medication as none had been authorized and he was unable to pay for them on his own. Previous medications were listed as Motrin, Mobic, Robaxin, and Norco. The March 2, 2015, lumbar spine MRI was noted to show lumbar spondylosis including the facet joints at L4-L5 and L5-S1 and degenerative disc disease with a 3mm disc protrusion at L5-S1. The March 2, 2015, right knee MRI was noted to show degenerative arthritis, a complex tear of the medial meniscus, a horizontal tear of the superior surface of the anterior horn of the lateral meniscus, mucoid degeneration of the anterior cruciate ligament, patellar chondromalacia, and a chronic sprain of the medial collateral ligament. The March 2, 2015, left knee MRI was noted to show mild to

moderate patellar chondromalacia, probable patellar tendon tendonitis, and mild degenerative arthritis. Physical examination was noted to show the lumbar spine with moderate plus tenderness over the lumbar spinous processes mainly at the lumbosacral junction, minimal tenderness in the paraspinal muscles, mild tenderness at the sacroiliac joints, and mild plus tenderness over the right sciatic nerve with very mild tenderness over the left sciatic nerve. The treatment plan was noted to include requests for authorization for an Aspen lumbar brace, Tramadol, and right knee arthroscopy with associated services.

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 Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

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.