

<b>Case Number:</b>	CM14-0180555		
<b>Date Assigned:</b>	11/05/2014	<b>Date of Injury:</b>	10/08/2012
<b>Decision Date:</b>	12/10/2014	<b>UR Denial Date:</b>	10/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/30/2014

### 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. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in North Carolina. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 33-year-old with a reported date of injury of 10/08/2012. The patient has the diagnoses lumbar degenerative disc disease, lumbosacral spondylosis, sacral disorder and sacroiliac joint arthralgia. Past treatment modalities have included epidural steroid injections, physical therapy and chiropractic care. Per the progress notes provided for review from the requesting physician dated 08/14/2014, the patient had complaints of low back pain radiating to the left buttock, lateral thigh and lateral calf. The physical exam noted tenderness in the L4/5 disc area, left sacroiliac sulcus. The left hip exam also had positive findings on the provocative maneuvers to include lateral compression, Faber, thigh thrust, distraction and gaelesen testing. There was also noted decreased sensation in the left lateral thigh. Treatment plan recommendations included lumbar MRI, lumbar x-rays and SI joint injection on the left.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**X-ray series of the lumbar spine with lateral flexion/extension views:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

**Decision rationale:** The ACOEM chapter on low back complaints and x-rays states: Lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. Routine x-rays are not recommended for acute, non-specific low back pain. X-rays are recommended for low back pain with red flags for fracture or serious systemic illness, sub-acute low back pain that is not improving or chronic low back pain as an option to rule out other possible conditions. This patient has ongoing low back pain with failure to respond to epidural steroid injections, physical therapy and chiropractic care. Therefore the criteria for low back x-rays have been from the ACOEM as outlined above and the request is medically necessary.

**MRI of the lumbar spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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. In discriminant 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 physical exam that shows nerve tissue insult or impingement besides decreased sensation on the left lateral thigh. There is no recorded presence of emerging red flags on the physical exam. For these reasons, criteria for imaging as defined above per the ACOEM have not been met. Therefore the request is not medically necessary.