

<b>Case Number:</b>	CM15-0114388		
<b>Date Assigned:</b>	06/22/2015	<b>Date of Injury:</b>	06/15/2013
<b>Decision Date:</b>	07/21/2015	<b>UR Denial Date:</b>	05/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2015

### 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 53 year old male who reported an industrial injury on 6/15/2013. His diagnoses, and/or impressions, are noted to include: lumbar spondylosis with radiculopathy; spinal stenosis and discopathy; and possible depression. No current imaging studies are noted. His treatments have included an initial medical-legal evaluation on 3/28/2015; an initial pain management-psychological evaluation/consultation on 4/9/2015; lumbar epidural steroid injections (12/11/13); medication management; and rest from work. The medical-legal evaluation notes of 3/28/2015 reported constant, moderate-severe pain in the low back, associated with pressure and numbness, that radiated to the right buttock, thigh, upper-mid back, and the left side of the neck, aggravated by activities, and somewhat relieved by taking prescribed medications; also reported was dizziness for which serial blood tests were being performed. Objective findings were noted to include moderate-severe distress from pain; guarded movements and restricted, slow gait with a right lean of the head, back and shoulder; and tenderness with spasm to the bilateral lumbosacral para-spinal musculature and right gluteus, with decreased and painful range-of-motion. The physician's requests for treatments were noted to include magnetic resonance imaging studies 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: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - Magnetic resonance imaging (MRIs).

**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. The review of the provided clinical documentation shows neurologic impairment and tissue insult. Therefore the request is medically necessary, as guideline recommendations have been met.