Case Number:	CM15-0119783		
Date Assigned:	06/30/2015	**Date of Injury:**	04/09/2014
Decision Date:	07/29/2015	**UR Denial Date:**	06/10/2015
Priority:	Standard	**Application Received:**	06/22/2015

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 55 year old male who sustained an industrial injury on 04/09/2014. Mechanism of injury occurred while standing at work and his right knee buckled causing to lose his balance. He was able to hold on to a chair to prevent him from falling to the ground, but he had right knee pain that continued to increase. Diagnoses include lumbar spine herniated nucleus pulpous, and right L5 radiculopathy, and moderate obesity. Treatment to date has included diagnostic studies, medications, physical therapy, and use of a Transcutaneous Electrical Nerve Stimulation unit. An unofficial report of a Magnetic Resonance Imaging of the lumbar spine done on 05/21/2014 revealed multilevel disc degeneration and disc herniation with mild to moderate lateral recess stenosis, and potential for impingement. On 11/10/2014 an unofficial Electromyography and Nerve Conduction Velocity study showed evidence of right active on chronic L5 radiculopathy, with no electro diagnostic evidence of lumbosacral plexopathy or mononeuropathy involving the bilateral tibial and peroneal nerves. A physician progress note dated 06/03/2015 documents the injured worker complains of severe low back pain that radiates into his right lower extremity. He has cramping in his right calf with numbness and tingling that radiates into his right heel. He rates his symptoms a 9 out of 10 on a pain scale of 0 to 10. His current medications include Cyclobenzaprine and Gabapentin. On examination there is moderate to severe lumbar paraspinal spasms, more so on the right. There is mild loss of sensation in the L5 nerve distribution on the right. The treatment plan includes aquatic therapy, and a neurosurgical consultation. Treatment requested is 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 of the lumbar spine: Upheld

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 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. There is no significant change in presentation or physical findings on exam since previous MRI. For these reasons, criteria for imaging as defined above per the ACOEM have not been met. Therefore, the request is not medically necessary.