

<b>Case Number:</b>	CM15-0096175		
<b>Date Assigned:</b>	05/27/2015	<b>Date of Injury:</b>	12/11/2013
<b>Decision Date:</b>	07/03/2015	<b>UR Denial Date:</b>	04/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/20/2015

### 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 51 year old female, who sustained an industrial injury on 12/11/2013. She reported a fall, hitting her right ankle and leg. The injured worker was diagnosed as having bilateral lumbar facet joint pain (L4-5 and L5-S1), lumbar facet joint arthropathy, chronic low back pain, right knee internal derangement, and right knee surgery (2010). Treatment to date has included diagnostics, physical therapy, bilateral L4-L5 and L5-S1 facet joint medial branch block (6 level on 10/17/2014 with 80% improvement and increased range of motion 30 minutes after injection, that lasted greater than 2 hours), bilateral L4-5 and L5-S1 facet joint radiofrequency nerve ablation on 3/19/2015, and medications. Currently, the injured worker complains of right and ankle knee pain and bilateral low back pain. Pain was not rated and functionality was not described. Current medications included Pennsaid, Naproxen, and Tramadol. Exam noted tenderness to palpation of the right knee, right ankle, and bilateral lumbar paraspinal muscles, overlying the L4-5 and L5-S1 facet joints. Lumbar range of motion was restricted by pain in all directions. Lumbar discogenic provocative maneuver was positive bilaterally. Sustained hip flexion and extension was positive bilaterally. Muscle strength was 5/5 in all limbs and sensation was intact. The treatment plan included magnetic resonance imaging of the lumbar spine, to evaluate for nerve root impingement, disc protrusion, stenosis, degenerative disc disease, and facet joint arthropathy. The Qualified Medical Examination (3/09/2015) was referenced, also with recommendation for magnetic resonance imaging of the lumbar spine, to document the presence of facet disease, noting that the injured worker discounted 80% relief from diagnostic injection. Her work status was part time, modified duty.

## 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 Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back chapter.

**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 certified.