

<b>Case Number:</b>	CM15-0098639		
<b>Date Assigned:</b>	06/01/2015	<b>Date of Injury:</b>	04/17/2012
<b>Decision Date:</b>	06/30/2015	<b>UR Denial Date:</b>	05/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/21/2015

### 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 36 year old male, who sustained an industrial injury on 4/17/12. Initial complaints were not reviewed. The injured worker was diagnosed as having disc protrusion at L4-S1; radiculopathy lumbar spine. Treatment to date has included medications. Diagnostics included EMG/NCV study left lower extremity (7/29/14). Currently, the PR-2 notes dated 4/10/15 indicated the injured worker complains of pain when sitting and standing along with anything else. His pain is in the upper back and at the night. He is being treated also by a Psychiatrist and waiting on a second opinion from a neuro spinal surgeon. Objective findings of the lumbar spine difficulty standing and is walking with a limp. He has numbness that is increased and is radiating down his left leg. He reports having pain at the L3-S1, bilateral posterior superior iliac spine and bilateral paravertebral muscle. The provider documents these measurements: "2ft, 15, 15/15, 30/30 all with pain." An EMG was done 7/29/14 of the left lower extremity and revealed left L5 radiculopathy. The PR-2 notes dated 2/27/15 has a physical examination of the lumbar spine that noted tenderness at that time at the spinous processes L3-S1. He had bilateral posterior superior iliac spine tenderness with bilateral paravertebral muscle tenderness and pain down the left leg. Range of motion showed forward flexion was 15 degrees and backward flexion was 0 degrees, lateral flexion 15 degrees bilaterally and lateral rotation was 20 degrees bilaterally. At that time, a second opinion from a neuro spine surgeon was being requested after the MRI of the lumbar spine was performed. The provider is requesting a MRI 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:** Overturned

**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.

**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. Criteria as outlined above have been met in the provided clinical documentation. Therefore, the request is medically necessary.