

Case Number:	CM13-0039013		
Date Assigned:	12/18/2013	Date of Injury:	07/29/2011
Decision Date:	03/13/2014	UR Denial Date:	09/04/2013
Priority:	Standard	Application Received:	10/02/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in Texas. 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 physician 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 54-year-old male who reported an injury on 07/29/2011. The patient is currently diagnosed with thoracic compression fracture, thoracic pain, cervical pain, cervical disc disorder, spinal/lumbar degenerative disc disease, low back pain, and disorder of the coccyx. The patient was seen by [REDACTED] on 12/18/2013. The patient reported 7-8/10 back pain. Physical examination revealed paravertebral muscle tenderness, lumbar range of motion, hypertonicity, and decreased sensation over the lateral foot, medial foot, medial and lateral calf on both sides. Treatment recommendations included an MRI of the lumbar spine as well as thoracic spine, flexion and extension view radiographs.

IMR ISSUES, DECISIONS AND RATIONALES

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

Magnetic resonance imaging (MRI) of the lumbar and/or sacral vertebrae: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) -TWC, Neck and Upper Back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Magnetic Resonance Imaging.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state 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, including MRI for neural or other soft tissue abnormality. As per the documentation submitted, the patient continuously reports lower back pain, with activity limitation and sleep disturbance. There is no documentation of a significant change in the patient's symptoms or physical examination findings. There is also no evidence of a recent failure to respond to conservative treatment. The medical necessity for the requested procedure has not been established. Therefore, the request is noncertified.

X-ray, lumbar spine: Upheld

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 (ODG) - TWC Low Back Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Radiography.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state 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 6 weeks. As per the documentation submitted, the patient has undergone previous lumbar spine x-rays. There is no change in the patient's symptoms or physical examination findings that would warrant the need for x-rays at this time. There is also no evidence of a failure to respond to recent conservative treatment. As the medical necessity has not been established, the request is noncertified.

X-ray of thoracic spine: Upheld

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 (ODG) - TWC Low Back Procedure Summary

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Radiography.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state thoracic spine x-rays should not be recommended in patients with back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least 6 weeks. As per the documentation submitted, the patient has undergone previous thoracic spine x-rays. There is no change in the patient's symptoms or physical examination findings that would warrant the need for x-rays at this time. There is also no evidence of a failure to respond to recent conservative treatment. As the medical necessity has not been established, the request is noncertified.