

Case Number:	CM14-0102282		
Date Assigned:	07/30/2014	Date of Injury:	02/11/2014
Decision Date:	10/02/2014	UR Denial Date:	06/19/2014
Priority:	Standard	Application Received:	07/02/2014

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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in California. 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/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 an injured worker with low back pain. Date of injury was 02-11-2014. Regarding the mechanism of injury, the patient injured his back pulling the jammed door of his vehicle open. Orthopaedic consultation note dated 6/4/2014 documented subjective complaints of low back pain. The patient reports having low back pain only and currently reports no lower extremity pain referable to the spine. The patient denies any neurologic signs or symptoms in the lower extremities. Bowel and bladder function is reported as normal. Physical examination was documented. Gait examination is normal, including heel/toe walking. Lumbosacral spine inspection is unremarkable. Muscle spasm is absent. Tenderness to palpation in the posterior lumbar spine is absent. Mild guarding was noted during the lumbar examination. Regarding range of motion, on forward flexion, fingertips come to the middle tibia. Extension is 20 degrees, lateral bend is 30 degrees bilaterally, and rotation is 30 degrees bilaterally. Lumbar spine nerve root provocation testing (straight leg raise sign) in a supine position is bilaterally negative. Lumbar spine nerve root provocation testing (straight leg raise sign) in a sitting position is bilaterally negative. Neurologic examination of both lower extremities was basically unremarkable with no significant findings noted. Motor strength was normal in all major muscle groups of the lower extremities and sensation was normal in all dermatomes of the lower extremities. No muscle atrophy is noted in any major muscle group of either lower extremity. Diagnoses were lumbosacral spondylosis, degenerative disc disease and facet arthrosis, transitional lumbosacral anatomy, and left sacroiliac joint syndrome. Treatment plan included lumbar MRI. Utilization review determination date was 6/19/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI lumbar spine w/o dye: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304, 308-310.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints states that 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). Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Table 12-8 Summary of Recommendations for Evaluating and Managing Low Back Complaints (Page 308-310) recommends MRI when cauda equina, tumor, infection, or fractures are strongly suspected. The orthopedic consultation note dated 6/4/2014 documented that the patient reported having low back pain only. The patient reported no lower extremity pain referable to the spine. The patient denied any neurologic signs or symptoms in the lower extremities. Gait examination was normal. Lumbosacral spine inspection was unremarkable. Muscle spasm was absent. Tenderness to palpation in the posterior lumbar spine was absent. Regarding range of motion, on forward flexion, fingertips come to the middle tibia. Lumbar spine nerve root provocation testing (straight leg raise sign) was bilaterally negative. Neurologic examination of both lower extremities was basically unremarkable with no significant findings noted. Motor strength was normal in all major muscle groups of the lower extremities and sensation was normal in all dermatomes of the lower extremities. No muscle atrophy was noted in any major muscle group of either lower extremity. There was no objective evidence of neurologic compromise. The patient reported no lower extremity pain referable to the spine. There were no surgical considerations. There were no red flags. There was no suspicion of equina, tumor, infection, or fracture. Per ACOEM guidelines, MRI of the lumbar spine is not supported. Therefore, the request for MRI lumbar spine w/o dye is not medically necessary.