

Case Number:	CM14-0057330		
Date Assigned:	07/09/2014	Date of Injury:	08/14/2013
Decision Date:	09/03/2014	UR Denial Date:	04/11/2014
Priority:	Standard	Application Received:	04/28/2014

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 Family Medicine and is licensed to practice in North Carolina. 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 a 48 year-old with a reported date of injury of 08/14/2013 that occurred when two boxes of compressed paper fell on the patient. The patient has the diagnoses of status post right knee surgery, tear of the medial meniscus of the left knee, bursitis of the right knee, lumbar sprain/strain, and rule out lumbar disc displacement without myelopathy. Per the most recent evaluation report dated 03/26/2014, the patient had complaints of occasional severe pain in the right knee, occasional moderate pain of the lumbar spine, and constant moderate pain of the left knee. The physical exam noted tenderness with spasm on the bilateral lumbar paraspinal muscles, pain with lumbar range of motion, no sensory deficits on dermatome testing, crepitus and pain in the right knee with decreased range of motion. The treatment recommendations included work hardening program, medications, 3D MRI of the lumbar spine and left knee, functional improvement measure through a functional capacity evaluation, work hardening screening, and psychosocial factors screen. The most recent progress notes from the primary treating physician dated 02/11/2014 states the patient had complaints of frequent and severe pain of the right knee and occasional pain of the lumbar spine. Physical exam noted spasm and tenderness of the lumbar spine with crepitus and pain in the right knee anterior joint line. Treatment recommendations at that time included an X-ray of the left foot.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI 3D Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The ACOEM section on special diagnostic studies in the low back complaints chapter 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, computer 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. The patient has no documented red flags or findings on physical exam to suggest nerve compromise. Therefore, the request for MRI 3D of the lumbar spine is not medically necessary.