

<b>Case Number:</b>	CM14-0076642		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	10/03/2013
<b>Decision Date:</b>	09/18/2014	<b>UR Denial Date:</b>	05/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/27/2014

### 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 Orthopedic and is licensed to practice in Arizona. 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:

This 34-year-old male was employed as an operator supervisor for UPS for 10 years but since June 2013 he experienced back pain soon after he started to work in a new department and had to do repetitive lifting 10-12 hours per day. After the back pain became especially noticeable on 10/3/2013 he was treated for left shoulder complaints while receiving minimal specific treatment for his back-related symptoms that could have. The only treatment that could have influenced the low back pain was Orphenadrine citrate, Nabumetone and Medrol Dosepak. These medications including physiotherapy were actually primarily prescribed for his shoulder complaint. The caregiver also prescribed a lumbo-sacral back support and 'Back Hugger'. On 10/9/2013 physician for first time reported low back pain not accompanied by lower extremity symptoms and he found no nerve compression or tension signs on examination. Lumbar plain x-rays showed no pathology and the diagnosis was stated as sprain lumbar spine. He was advised to return to work on 10/9/2013. When Neurologist saw patient on 10/3/2013, his low back status was not addressed. On 10/5/2014 he was seen for first orthopedic evaluation and concentrated on his back-related symptoms. The patient, at that stage, complained of constant upper and lower back pain, with no referred pain. He also mentioned, without giving detail, recent weight gain, of 40 pounds and bouts of depression, anxiety and insomnia. An examination revealed moderate decreased range of back motion as the only physical finding. The diagnostic studies are reported below. The diagnosis was stated as lumbar strain and suggested to obtain authorization for lumbar MRI of lumbar spine without contrast. The diagnostic studies consisted of an electromyography (EMG) and nerve conduction velocity (NCV) of left upper extremity. Diagnosis was documented as: The Neurologist, concentrating on shoulder complaints, after reviewing EMG/NCV diagnosed: severe ulnar neuropathy, left carpal tunnel syndrome, peripheral neuropathy but no cervical radiculopathy, low back pain due to lumbo-sacral sprain.

## 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:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299,300,301,303,305,360. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back, MRI.

**Decision rationale:** The Medical Treatment Utilization Schedule ACOEM Guidelines state that evidence of nerve dysfunction should be obtained before ordering an imaging study. However in this case there was no evidence of nerve dysfunction. Indiscriminate imaging can also result in false-positive findings, such as disk bulges, that may not be the source of the painful symptoms. The guidelines further note that MRI is recommended when cauda equina, tumor, infection, or fracture is strongly suspected and plain radiographs are negative. In this case, there are no unequivocal findings of nerve compromise or evidence of cauda equina syndrome, tumor, infection, or suspected fracture. The Official Disability Guidelines [ODG] does not recommend MRI's for patients with uncomplicated low back pain until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. Therefore, the available medical records do not support the medical necessity for a MRI of the lumbar spine at this time.