

Case Number:	CM14-0088245		
Date Assigned:	07/23/2014	Date of Injury:	08/22/2012
Decision Date:	09/18/2014	UR Denial Date:	05/30/2014
Priority:	Standard	Application Received:	06/12/2014

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 Occupational 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:

There were 59 pages for review. The application for independent medical review was signed on June 10, 2014. It was for the MRI of the lumbar spine. Per the records provided, the patient complains of pain in the bilateral low back. The injury was on August 22, 2012. The pain level was seven out of 10. The pain radiated to the left foot and toes. There was weakness and numbness in the left leg, in the left foot and the big toe. He is described as a 43-year-old male. The patient is diagnosed with lumbar myospasm. His medicines included tramadol, Protonix, and Naprosyn. Diagnostic studies in the past were not provided. He was evaluated on April 4, 2014 and had low back, mid back and I pain. There was weakness and numbness in the left lower extremity. The physical exam revealed restricted range of motion and decreased sensation, but there was no mention of an attempt at conservative treatment prior to this request for an imaging study. This was the basis for the non-certification. There was an April 4, 2014 primary treating physician's supplemental report. The claimant still feels the same and still complains of low back, mid back and eye pain. There was tenderness to palpation, guarding and spasms noted in the left paravertebral region. There were some trigger points. There was decreased sensation to light touch, left greater than right. Myotome testing revealed four out of five at L5, L4 and S1. The diagnosis was again lumbar myospasm. The doctor requested both this MRI of the lumbar spine and x-rays including AP, lateral, flexion and extension views. There were earlier notes provided from December. He works as a cleaner. He was cleaning the diesel tanks on the ground and he slipped on some fuel hurting his left knee and the low back had a ripping sensation. The diagnoses were lumbar myalgia, lumbar mild spasm and left-sided lumbar neuritis were radiculitis. The doctor requested the MRI and imaging studies as an outcome of his initial orthopedic evaluation. The date of the exam was December 3, 2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI for the Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 11th Edition (web), 2013, Low Back Chapter, Magnetic Resonance Imaging (MRI).

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

Decision rationale: Under MTUS/ACOEM, although there is subjective information presented in regarding increasing pain, there are little accompanying physical signs. Even if the signs are of an equivocal nature, the MTUS note that electrodiagnostic confirmation generally comes first. They note '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. The guides warn that indiscriminate imaging will result in false positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. The ODG guidelines note, in the Low Back Procedures section:- Lumbar spine trauma: trauma, neurological deficit- Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit)- Uncomplicated low back pain, suspicion of cancer, infection- Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. (For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383.) (Andersson, 2000)- Uncomplicated low back pain, prior lumbar surgery- Uncomplicated low back pain, cauda equina syndrome. These criteria are also not met in this case; the request was appropriately not medically necessary under the MTUS and other evidence-based criteria.