

Case Number:	CM14-0202738		
Date Assigned:	12/15/2014	Date of Injury:	01/22/2014
Decision Date:	02/05/2015	UR Denial Date:	11/13/2014
Priority:	Standard	Application Received:	12/04/2014

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 Practice 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:

This is a 37 year old male patient who sustained a work related injury on 1/22/14. Patient sustained the injury when he was pulling and cutting a bush out of the planter bed and as he was tugging on the bush, he felt a sharp pain in the middle of his back. The current diagnosis includes low back pain. Per the PT note dated 11/25/14, patient has complaints of increased right side low back pain and groin pain. Physical examination of the low back revealed decreased functional use secondary to pain and weakness. Per the doctor's note dated 10/29/14 patient had complaints of low back pain at 4-5/10 that radiates to left lower extremity with tingling and numbness. Physical examination revealed no swelling, tenderness on palpation, muscle spasm, 5/5 strength and negative SLR. The current medication lists include Tramadol, Nabumatone, Cyclobenzaprine and Omeprazole. The patient has had MRI of the lumbar spine on 2/13/14 that revealed very minimal disc bulging at L4-5 and L5-S1 with no significant narrowing of the spinal canal or distortion of the thecal sac, minimal disc bulging at the neural foramina at L2-3, L3-4 and L5-S1, mild at L4-5 not compression the nerve roots at any of these levels, mild facet degenerative changes at L4-5 and L5-S1 and EMG on 3/26/14 that was normal. The patient's surgical history includes epidural steroid injection at L5-S1 on 6/13/14. Per the doctor's note dated 10/29/14 physical examination revealed no swelling, 5/5 strength and negative SLR. Any significant functional deficits of the low back that would require MRI of the low back was not specified in the records provided. The patient has received an unspecified number of PT visits for this injury. The patient has used H-wave for this injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the Lumbar Spine: 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): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Online Edition, Chapter: Low Back (updated 11/21/14), MRIs (magnetic resonance imaging)

Decision rationale: Per the ACOEM Practice Guidelines, low back chapter cited below, "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, computed tomography [CT] for bony structures)." ACOEM/MTUS guideline does not address a repeat MRI. Hence the Official Disability Guidelines were used. Per the Official Disability Guidelines, low back chapter cited below, "Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neuro compression, and recurrent disc herniation)." The patient has had MRI of the lumbar spine on 2/13/14 that revealed very minimal disc bulging at L4-5 and L5-S1 with no significant narrowing of the spinal canal or distortion of the thecal sac, minimal disc bulging at the neural foramina at L2-3, L3-4 and L5-S1, mild at L4-5 not compression the nerve roots at any of these levels, mild facet degenerative changes at L4-5 and L5-S1 and EMG on 3/26/14 that was normal. The patient did not have any evidence of severe or progressive neurologic deficits that are specified in the records provided. Any finding indicating red flag pathologies were not specified in the records provided. The history or physical exam findings did not indicate pathology including cancer, infection, or other red flags. As per records provided patient has received an unspecified number of physical therapy for this injury till date. A detailed response to complete course of conservative therapy including physical therapy visits was not specified in the records provided. Previous physical therapy visit notes were not specified in the records provided. A plan for an invasive procedure of the lumbar spine was not specified in the records provided. The medical necessity of the MRI of the lumbar spine is not fully established for this patient. Therefore, this request is not medically necessary.