

<b>Case Number:</b>	CM14-0204685		
<b>Date Assigned:</b>	12/17/2014	<b>Date of Injury:</b>	08/28/2009
<b>Decision Date:</b>	02/04/2015	<b>UR Denial Date:</b>	11/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/08/2014

### 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 Ohio. 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 40 year old male who sustained an industrial injury to his low back on 08/28/2009. The patient was thrown to the ground, striking metal bars by a hose while laying cement. The patient has been diagnosed with s/p left wrist carpal tunnel release and ulnar shortening 11/24/2010, left wrist and hand pain with history of left wrist ORIF secondary to fracture and low back pain/lumbar sprain. The patient states his pain level is 5 of 10 without medications and 1 of 10 with medications. Treatments provided to the patient included medications, sleep specialist, CPAP machine and x-rays of the lumbar spine which were not submitted for review. It appears the injured worker had acupuncture, physical therapy, and chiropractic care for the lower back in 2011. The patient is now noticing progressive difficulties with back pain in addition to bilateral feet pain and has requested an MRI of the lumbar spine. The physical exam reveals diminished lumbar range of motion. The most recent, lower extremity neurologic exam submitted for review was from 5-5-2012 and was normal. Utilization Review dated 11/17/2014 denied requested MRI of the lumbar spine per California Medical Treatment Utilization Schedule, Low Back Complaints. The denial stated the MRI was not medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI lumbar spine:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Lumbar & Thoracic, MRIs

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, MRI American Family Physician. 1999 Nov 15;60(8):2299-2306. Low Back Pain

**Decision rationale:** The Official Disability Guidelines state that MRI imaging of the lumbar spine is appropriate when: Indications for imaging -- Magnetic resonance imaging:- Thoracic spine trauma: with neurological deficit- 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, other "red flags"- Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. - Uncomplicated low back pain, prior lumbar surgery- Uncomplicated low back pain, cauda equina syndrome- Myelopathy (neurological deficit related to the spinal cord), traumatic- Myelopathy, painful- Myelopathy, sudden onset- Myelopathy, stepwise progressive- Myelopathy, slowly progressive- Myelopathy, infectious disease patient- Myelopathy, oncology patient After ruling out "red flags, there is considerable value in first determining whether or not there are radicular signs. This will allow branching based on generalized low back pain including sprains and strains, versus potential disc problems. Determine radiculopathy via sensation (pain radiating below the knee) not just referred pain (pain radiating to buttocks or thighs), & dermatological sensory loss, plus straight leg raising test (sitting & supine), motor strength (deep tendon reflexes), flexibility (fingertip test), muscle atrophy (calf measurement), and local areas of tenderness. Among the "red flags" for serious abnormalities are inflammatory disease, fracture, referred pain (eg, from rupturing aortic aneurysm), infection, or cancer. In this study only 11 of 1172 (0.9%) patients were confirmed as having a serious spinal condition, including spinal fracture (n = 8), cauda equina syndrome (n = 1), or inflammatory disorder (n = 2). No patients were identified with cancer or infection as the cause of their pain. For spinal fractures, the diagnostic accuracy of the following red-flag questions was determined: (1) age > 70 years; (2) significant trauma; (3) prolonged corticosteroid use; & (4) altered sensory level (from the trunk down). The authors concluded that serious spinal abnormalities are rare in primary care settings, and the questions on the possibility of fracture may be useful. In this instance, the history and physical examinations are not consistent with radiculopathy. The pain has been non-radiating and the neurologic exam is normal and 'unchanged'. The injured worker is described as having pain in the feet but there is no discussion of whether this pain is radiating or not and no corresponding neurologic exam was submitted. In fact, there is no submitted physical exam of the feet. It is noted that the injured worker did have conservative treatment initially including physical therapy and chiropractic care. Acute low back pain is commonly treated by family physicians. In most cases, only conservative therapy is needed. However, the history and physical examination may elicit warning signals that indicate the need for further work-up and treatment. These "red flags" include a history of trauma, fever, incontinence, unexplained weight loss, a cancer history, long-term steroid use, parenteral drug abuse, and intense localized pain and an inability to get into a comfortable position. In this instance, the history and physical examinations are not suggestive of radiculopathy. However, there was back trauma associated with the initial injury. Therefore,

even though a clear cut case cannot be made for radiculopathy, because there is a red flag here historically, an MRI scan of the lumbar spine is medically necessary.