

Case Number:	CM15-0006843		
Date Assigned:	01/26/2015	Date of Injury:	01/20/2012
Decision Date:	04/07/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/13/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, Hawaii
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 injured worker is a 56-year-old male, who sustained an industrial injury on 1/20/2012. He has reported being hit on the head and right ear resulting in daily headaches. The diagnoses have included cervical pain, occipital neuralgia, post-concussion syndrome and migraine. Treatment to date has included medication therapy, physical therapy, cervical branch blocks and cervical epidural steroid injections. Currently, the IW complains of neck pain, headaches, and low back pain. Pain was rated 8/10 VAS without medication and 5-6/10 VAS with medications. The provider documented authorization for a lumbar Magnetic Resonance Imaging (MRI) was still pending. The physical examination from 1/16/15 documented observation of mild distress, fatigue and moderate pain. Lumbar spine demonstrated pain with palpation, muscle spasms, and positive bilateral lumbar facet loading tests. Cervical spine demonstrated spasms and tenderness on the right side, decreased Range of Motion (ROM), and positive cervical facet loading. The plan of care included obtaining MRIs, obtaining a neurosurgical consultation, obtaining a psychological examination, continued physical therapy and home exercise, and medications. On 12/23/2014 Utilization Review non-certified a Lumbar spine Magnetic Resonance Imaging (MRI) with and without contrast, noting the documentation did not support that guidelines were met. The MTUS and ODG Guidelines were cited. On 1/13/2015, the injured worker submitted an application for IMR for review of Lumbar spine Magnetic Resonance Imaging (MRI) with and without contrast.

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, with and without contrast: Upheld

Claims Administrator 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), Treatment Index, 12th Edition (web), 2014, Low Back-MRI.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low back chapter, MRI imaging.

Decision rationale: The patient suffers chronic neck pain and headaches, and also experiences some low back pain. The current request is for MRI Lumbar Spine with/without contrast. The ODG states that diagnostic imaging of the spine is associated with a high rate of abnormal findings in asymptomatic individuals. Herniated disk is found on magnetic resonance imaging in 9% to 76% of asymptomatic patients; bulging disks, in 20% to 81%; and degenerative disks, in 46% to 93%. Baseline MRI findings do not predict future low back pain. MRI findings may be preexisting. Many MRI findings (loss of disc signal, facet arthrosis, and end plate signal changes) may represent progressive age changes not associated with acute events. MRI abnormalities do not predict poor outcomes after conservative care for chronic low back pain patients. The new ACP/APS guideline as compared to the old AHCPR guideline is more forceful about the need to avoid specialized diagnostic imaging such as magnetic resonance imaging (MRI) without a clear rationale for doing so. A new meta-analysis of randomized trials finds no benefit to routine lumbar imaging (radiography, MRI, or CT) for low back pain without indications of serious underlying conditions, and recommends that clinicians should refrain from routine, immediate lumbar imaging in these patients. There is support for MRI, depending on symptoms and signs, to rule out serious pathology such as tumor, infection, fracture, and cauda equina syndrome. Patients with severe or progressive neurologic deficits from lumbar disc herniation, or subjects with lumbar radiculopathy who do not respond to initial appropriate conservative care, are also candidates for lumbar MRI to evaluate potential for spinal interventions including injections or surgery. The indications for MRI include trauma and neurological deficit. In this case, the attending physician fails to offer a diagnoses relating to the lumbar spine. As a side note, the attending physician notes that the patient is experiencing low back pain in addition to his ongoing chronic neck pain and headaches. Physical exam findings noted positive lumbar facet loading, but was negative for signs of nerve tension, loss of sensation, diminished reflex or diminished motor strength. The attending physician offers no clear rationale for requesting an MRI of the lumbar spine and as such, the recommendation is for denial.