

Case Number:	CM15-0106961		
Date Assigned:	06/11/2015	Date of Injury:	01/09/2014
Decision Date:	07/14/2015	UR Denial Date:	05/26/2015
Priority:	Standard	Application Received:	06/03/2015

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: Texas, Florida, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 55-year-old female, who sustained an industrial injury on 1/9/14. She reported initial complaints of neck, left upper extremity, back and left lower extremity pain. The injured worker was diagnosed as having chronic neck pain; cervical degenerative disc disease; chronic low back pain. Treatment to date has included physical therapy; urine drug screening; medications. Diagnostics included X-rays cervical and lumbar spine (12/9/13); X-rays lumbar spine (5/15/15). Currently, the PR-2 notes dated 4/17/15 indicated the injured worker complains of low back, neck, left arm and left leg pain. The provider notes she was last seen in the clinic on 3/20/15. She continues to complain of low back pain, which radiates to the left leg. She also complains of numbness in her left leg. She complains of left-sided neck pain, which radiates to her left arm. Her pain is a little better by 20% as she completed 6 sessions of physical therapy. The injured worker rates her pain at 7/10 with medication and 5/10 with medications. On physical examination of the cervical spine, it is documented range of motion flexion at 0-40 degrees, extension 0-20 degrees, rotation 0-20 to the left and 0-45 on the right. There is tenderness over the left cervical and lumbar paraspinal muscles. She is able to ambulate without any devices with an antalgic gait. X-rays are documented within the records (dated 8/23/14) of the cervical and lumbar spine dated 12/9/13. It is documented the cervical spine x-rays reveal mild discogenic disease at C4-5 to C6-7. Anterior osteophytes are present at these levels, calcification of PLL. Mild left C4-5 NF narrowing. The lumbar spine x-rays reveal grade I anterolisthesis of L4 and L5. Consider oblique images to evaluate possible pars defect. The provider is requesting a MRI of the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): American College of Occupational and Environmental Medicine Page 303, Low Back Complaints.

Decision rationale: This claimant was injured 1-9-14. There is neck, left upper extremity, back and left lower extremity pain. There is degenerative change on x-ray of the neck. The lumbar x-rays show grade I anterolisthesis of L4 and L5. There is no mention of objective neurologic signs or symptoms or changes in such since past imaging studies. 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. I did not find electrodiagnostic studies. It can be said that ACOEM is intended for more acute injuries; therefore other evidence-based guides were also examined. 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 non-certified under the MTUS and other evidence-based criteria. Therefore, the request for MRI lumbar spine is not medically necessary.