

Case Number:	CM15-0014772		
Date Assigned:	02/02/2015	Date of Injury:	10/10/2012
Decision Date:	04/07/2015	UR Denial Date:	12/31/2014
Priority:	Standard	Application Received:	01/26/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 23 year old male, who sustained an industrial injury on October 10, 2012. He has reported injury to his left ankle, foot and back. The diagnoses have included thoracic spine sprain/strain, lumbar spine radicular complaints, left knee sprain/strain and left ankle/foot sprain/strain. Treatment to date has included diagnostic studies, medicated creams, TENS unit, medication, walking boot, physical therapy and injection to the left ankle/foot. Progress report dated December 22, 2014 is illegible and contains limited information. On July 10, 2014, the injured worker complained of pain located in the mid back described as achy and sharp. He complained of pain to his lumbosacral spine described as an achy, sharp pain with radiation down the left leg to the foot. There was numbness and tingling in the left leg some of the time. His pain is increased with standing, sitting, squatting, stooping, walking, pushing, pulling, lifting, twisting, turning, carrying, bending and climbing stairs. His activities of daily living and sleep are affected due to the pain. On January 2, 2015, Utilization Review non-certified an MRI for the lumbar spine, noting the Official Disability Guidelines. On January 26, 2015, the injured worker submitted an application for Independent Medical Review for review of MRI for the lumbar spine.

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: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177.

Decision rationale: ACOEM guidelines support ordering of imaging studies for emergence of red flags, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The documentation submitted for review indicates that the requesting physician claimed that the patient had never had an MRI of his lumbar spine. However, within the medical records it is noted that MRI of the lumbar spine was performed 11/29/12 which "revealed an essentially normal MRI of the lumbar spine with minimal hypertrophic change of the facet joints at L4-5 and L5-S1 likely within the normal range, no significant disc protrusion or extrusion and there is no evidence of central canal or foraminal stenosis at any level, no evidence of fracture or spondylolisthesis." Per progress report dated 7/10/14, the injured worker complained of pain in the mid back and pain in the lumbosacral spine that radiated down to the left leg to the foot. There was also numbness and tingling in the left leg. In light of these neurologic changes, the request is medically necessary. I respectfully disagree with the UR physician's assertion that MRI of the lumbar spine was previously authorized in 9/2014, review of the available records does not indicate this.