

<b>Case Number:</b>	CM15-0142496		
<b>Date Assigned:</b>	08/03/2015	<b>Date of Injury:</b>	05/31/2014
<b>Decision Date:</b>	09/03/2015	<b>UR Denial Date:</b>	06/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/22/2015

### 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, California  
 Certification(s)/Specialty: Family Practice

### 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 34-year-old male, who sustained an industrial injury on 5-31-14. He reported left wrist pain. Many of the medical reports are difficult to decipher. The injured worker was diagnosed as having lumbar spine sprain and strain. Treatment to date has included physical therapy and acupuncture. Currently, the injured worker complains of lumbar spine pain. The treating physician requested authorization for a MRI of the lumbar spine. The medication list include Zanaflex and Anaprox. The patient's surgical history include hernia repair in 9/12/2014. The patient had received an unspecified number of PT visits for upper extremity Other therapy done for low back was not specified in the records provided. A current physical therapy evaluation note was not specified in the records provided. Per the note dated 5/19/15, the patient had diagnosis of mid and low back pain. A recent detailed physical examination of the lumbar spine was not specified in the records specified. Per the note dated 7/22/15 the physical examination of the lumbar spine revealed positive SLR, tenderness on palpation and decreased sensation in lower extremity. There is no documentation of the low back symptoms prior to 7/22/15. Detailed response of the conservative treatment for the lumbar spine including oral pharmacology, was not specified in the records specified.

### 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.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 303-304.

**Decision rationale:** Request: MRI lumbar spine. Per the ACOEM low back guidelines 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)." There is no documentation of the low back symptoms prior to 7/22/15. 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. Patient has received an unspecified number of PT visits for this injury. The records submitted contain no accompanying current PT evaluation for this patient. A detailed response to a complete course of conservative therapy including medications and PT visits for the low back was not specified in the records provided. Previous PT 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. A recent lumbar spine X-ray report is not specified in the records provided. The medical necessity of the MRI of the lumbar spine is not fully established for this patient.