

Case Number:	CM15-0160681		
Date Assigned:	08/27/2015	Date of Injury:	03/05/2013
Decision Date:	09/29/2015	UR Denial Date:	08/05/2015
Priority:	Standard	Application Received:	08/17/2015

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: North Carolina
 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 62 year old male, who sustained an industrial injury on March 5, 2013. He reported neck and low back pain as well as bilateral shoulders, hands and wrists. The injured worker was diagnosed as having carpal tunnel syndrome, degenerative disc disease, wrist pain, cervical sprain-strain, finger sprain-strain, bilateral hands sprain-strain, right elbow sprain-strain and bilateral shoulders sprain-stain. Treatment to date has included cervical epidural injection, MRI, electrodiagnostic study, pain management, trigger point injections, physical therapy (prior to claim-ultrasound therapy, acupuncture and physical therapy). Currently, the injured worker complains of neck pain. He experiences severe pain located on the top of his head when he bends his neck to the left or right. He reports low back pain that radiates down his lower extremities bilaterally and is aggravated by prolonged standing and negotiating stairs. He reports occasional headaches, as well as bilateral hand and wrist pain. He rates his pain at 4-5 on 10. The pain interferes with his ability to function, engage in activities of daily living and interferes with his ability to sleep. The injured worker is currently diagnosed with cervical-lumbar spine sprain-strain and bilateral carpal tunnel syndrome. His work status is temporary total disability. A note dated June 24, 2015 states the injured workers pain is reduced from 7 on 10 to 5 on 10 with medication. The note also states the injured worker experienced therapeutic efficacy for three days, 50%-80%, from the cervical epidural injection. The injured worker experienced pain relief from trigger point injections, per note dated June 24, 2015. A progress note dated July 13, 2015 states Norco is helpful in controlling his pain. The therapeutic response to ultrasound

therapy, acupuncture and physical therapy were not included in the documentation. A lumbar MRI to assist with further diagnosis is requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI lumbar: Upheld

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

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

Decision rationale: The ACOEM chapter on low back complaints and special diagnostic studies states: 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). Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false positive test results) because of the possibility of identifying a finding that was present before symptoms began and therefore has no temporal association with the symptoms. Techniques vary in their abilities to define abnormalities (Table 12-7). Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Because the overall false-positive rate is 30% for imaging studies in patients over age 30 who do not have symptoms, the risk of diagnostic confusion is great. There is no recorded presence of emerging red flags on the physical exam. There is evidence of nerve compromise on physical exam but there is not mention of consideration for surgery or complete failure of conservative therapy. For these reasons, criteria for imaging as defined above per the ACOEM have not been met. Therefore, the request is not medically necessary.