

Case Number:	CM15-0184870		
Date Assigned:	09/23/2015	Date of Injury:	09/07/2014
Decision Date:	10/29/2015	UR Denial Date:	09/02/2015
Priority:	Standard	Application Received:	09/21/2015

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 58-year-old male, with a reported date of injury of 09-07-2014. The diagnoses include likely disk herniations versus injury at L4-5 and, or L5-S1 and moderate muscle spasm in the lumbar region. Treatments and evaluation to date have included physical therapy. The diagnostic studies to date have included an MRI of the left knee. The initial pain management consultation report dated 08-13-2015 indicates that the injured worker complained of bilateral knee pain and low back pain. He stated that his low back pain was worse than his knee pain. The injured worker rated his pain 8-9 out of 10 depending on his activities of daily living. The pain was described as a stinging and sharp sensation in the low back with numbness in his left lower extremity. It was noted that the injured worker was unable to do activities of daily living such as bending, lying down, driving, stress, sexual activity, rising from a chair, lifting, bending, and stooping. The treating physician stated that the injured worker was not taking any medications at this time. The physical examination showed moderately severe muscle spasm to palpation of the bilateral lumbar spine; lumbar flexion at 45 degrees; lumbar extension at 50 degrees; lumbar right rotation at 30 degrees; lumbar left rotation at 30 degrees; lumbar right side bending at 20 degrees; lumbar left side bending at 30 degrees; positive straight leg raise test in the supine position at 60 degrees; positive Kemp test on the left; and negative straight leg raise test in the sitting position. The treatment plan included an MRI of the lumbar spine. The injured worker was to remain temporarily totally disabled until the MRI of the lumbar spine has been performed. The request for authorization was dated 07-31-2015. The treating physician requested an MRI of the lumbar spine. On 09-02-2015, Utilization Review (UR) non-certified the request for an 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 (magnetic resonance imaging) of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation, and Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

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.