

Case Number:	CM15-0198593		
Date Assigned:	10/14/2015	Date of Injury:	11/10/1994
Decision Date:	11/30/2015	UR Denial Date:	09/23/2015
Priority:	Standard	Application Received:	10/09/2015

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 73 year old male who sustained an industrial injury on 11-10-94. A review of the medical records indicates he is undergoing treatment for pain in joint involving shoulder region and pain in limb. Medical records (4-10-15, 5-8-15, 6-19-15, and 7-10-15) indicate ongoing complaints of low back pain and left leg pain. He also has complained of right shoulder, right knee, and right leg pain. He rates his pain "8-10 out of 10" without medications. His pain with the use of medications has varied from "5-9 out of 10". On 7-10-15, he presented for a routine office visit and reported that his "left leg hurts more". The physical exam (7-10-15) reveals tenderness over the lumbosacral area on the left wide with "20% restriction of flexion". The treating provider states "unable to extend". Lateral bending is "30% restricted". Internal and external rotation of the hips is noted to be non-tender. The treating provider indicates that there are "no diagnostic studies for new changes of his back". An "MRI" is noted to have been completed "remotely". The treatment has included activity modification, use of ice and heat, a home exercise program, and medications. A request for authorization of an MRI of the lower back was made. The utilization review (9-23-15) includes a request for authorization of an MRI of the lumbar spine without contrast. The request was denied.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the lumbar spine (lower back) without contrast: Upheld

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

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.