

Case Number:	CM15-0223181		
Date Assigned:	11/19/2015	Date of Injury:	07/15/2015
Decision Date:	12/30/2015	UR Denial Date:	10/30/2015
Priority:	Standard	Application Received:	11/16/2015

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, Florida, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 47 year old female, who sustained an industrial injury on 7-15-2015. The injured worker was being treated for strain of muscle, fascia, and tendon of lower back. The injured worker (8-20-2015) reported ongoing lower back pain radiating into the left lower extremity and limited back range of motion. The physical exam revealed spasms and tenderness of the thoracolumbar spine and paravertebral musculature, restricted range of motion, and intact sensation to light touch in all dermatomes of the bilateral lower extremities. The injured worker (9-16-2015) reported ongoing non-radiating lower back pain. The physical exam revealed tenderness of the thoracolumbar spine and paravertebral musculature, restricted range of motion, and intact sensation to light touch in all dermatomes of the bilateral lower extremities. The injured worker (10-21-2015) reported ongoing lower back pain radiating into the left lower extremity and limited back range of motion. The physical exam revealed spasms and tenderness of the thoracolumbar spine and paravertebral musculature, restricted range of motion, and intact sensation to light touch in all dermatomes of the bilateral lower extremities. Per the treating physician (10-15-2015 report), the x-rays of the lumbar spine (8-5-2015) demonstrated degenerative joint changes. Treatment has included physical therapy, work modifications, a back support, and medications including pain, muscle relaxant, and non-steroidal anti-inflammatory. Per the treating physician (10-21-2015 report), the injured worker continues to work with restrictions. On 10-21-2015, the requested treatments included an MRI for the lumbosacral. On 10-30-2015, the original utilization review non-certified a request for an MRI for the lumbosacral.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI for the lumbosacral: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

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

Decision rationale: American College of Occupational and Environmental Medicine, page 303, Low Back Complaints. This claimant was injured in July with a low back strain. As of August, there was still low back pain and restricted range of motion. There was intact sensation in all dermatomes. X-rays showed degenerative changes. Under MTUS/ACOEM, although there is subjective information presented in regarding increasing pain, there are little accompanying physical signs. Even if the signs are of an equivocal nature, the MTUS note that electrodiagnostic confirmation generally comes first. They note "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." The guides warn that indiscriminate imaging will result in false positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. I did not find electrodiagnostic studies. It can be said that ACOEM is intended for more acute injuries; therefore other evidence-based guides were also examined. The ODG guidelines note, in the Low Back Procedures section: Lumbar spine trauma: trauma, neurological deficit. Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit). Uncomplicated low back pain, suspicion of cancer, infection. Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. (For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383.) (Andersson, 2000). Uncomplicated low back pain, prior lumbar surgery. Uncomplicated low back pain, cauda equina syndrome. These criteria are also not met in this case; the request is not medically necessary.