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| Case Number: | CM15-0083978 | | |
| Date Assigned: | 05/06/2015 | Date of Injury: | 02/11/2015 |
| Decision Date: | 06/12/2015 | UR Denial Date: | 04/16/2015 |
| Priority: | Standard | Application Received: | 05/01/2015 |

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: California, Hawaii
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 33 year old male who sustained an industrial injury on 02/11/2015. Current diagnoses include strain lumbosacral and pain thoracic spine. Previous treatments included medication management and physical therapy. Previous diagnostic studies include x-rays. Initial complaints included pain in the lower back after carrying a toilet up a flight of stairs. Report dated 03/31/2015 noted that the injured worker presented with complaints that included pain from his right low thoracic area to his left mid thoracic region. The injured worker did note that he does feel better following the completion of the 6 sessions of physiotherapy. Pain level was not included. Physical examination was positive for tenderness in the left mid back and upper right lumbar/low thoracic region. The treatment plan included request for an MRI due to the persistent pain from the right low thoracic back to the left mid back despite physiotherapy, continue with conservative care of warm/cool compresses and modified duty, continue medications as directed, and refilled Ultram. Disputed treatments include MRI of the lumbar spine without dye.

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: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low back, MRI.

Decision rationale: The patient presents with pain affecting the right low thoracic area to his left mid thoracic region. The current request is for MRI of the lumbar spine. The treating physician report dated 3/31/15 (30B) states, Due to persistent pain from the right low thoracic back to the left mid back despite physiotherapy we will request an MRI. The MTUS guidelines do not address the current request. The ODG has the following regarding MRI of the lumbar spine: Recommended for indications below. MRI's are test of choice for patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy, not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). The documents provided, do not show that the patient has received a prior MRI of the lumbar spine or that the patient is status post back surgery. In this case, while the patient has failed at least a month of physical therapy, there is no evidence of radiculopathy in the medical reports provided as required by the ODG guidelines. Recommendation is for denial and the request is not medically necessary.