

Case Number:	CM14-0136712		
Date Assigned:	10/14/2014	Date of Injury:	12/16/2013
Decision Date:	11/13/2014	UR Denial Date:	07/22/2014
Priority:	Standard	Application Received:	08/22/2014

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. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 37-year old preschool teacher reported injuries to her neck and back due to a fall at work on 12/16/13. Initial treatment included medications, physical therapy and chiropractic treatment. The patient changed providers, and was seen by her current primary treater for the first time on 3/17/14, at which time he stated that she needed "MRI cervical and lumbar spine or will EMG/NCS leg". A follow-up report from the primary treater dated 4/9/14 states that the patient continues to have back and neck pain and "symptoms throughout the left upper extremity". Exam findings include a positive straight leg raise (symptoms produced by leg raise not documented). Diagnoses: cervical strain with left arm symptoms, radiculopathy, and rule out herniated disc. Treatment plan: MRI of the cervical and lumbar spine, and EMG nerve conduction study (site not specified). Physical therapy is requested. A 5/21/14 progress note from the primary treater documents continued back and neck pain, and decreased range of motion of the neck, back and both shoulders. Jamar grip strength is markedly low in both hands. No sensory exam is documented. Diagnoses: cervical and lumbar strain, shoulder tendinitis, and tingling and numbness of the upper extremity. Plan: EMG and nerve conduction study of the upper extremity, appeal of MRI denial, a second opinion if first two requests not authorized. An orthopedic consultation dated 7/12/14 from a different provider documents patient complaints of neck and back pain, with numbness and tingling of her entire left upper extremity. The back pain radiates to the left buttock, but not below it. Symptoms do not worsen with cough or sneeze. Exam findings include tenderness, mildly decreased range of motion of the neck and back, and markedly decreased Jamar grip strength testing bilaterally. Sensation is decreased in the left C5-6 dermatome. Strength and sensation are normal in the lower extremities and straight leg raise is negative bilaterally. Diagnoses include cervical sprain, consider disc, and lumbosacral sprain with intermittent left radiculitis. The provider states that the patient is

currently in need of an MRI of the cervical and lumbar spine, as well as of ENG/nerve conduction studies of both upper extremities.

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: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The reference cited above states that unequivocal findings on neurologic exam that identify specific nerve root compromise provide enough evidence to warrant an MRI. When the neurologic findings are less clear, other physiologic evidence of nerve dysfunction should be obtained before imaging. Indiscriminate imaging may result in false positive findings such as disc bulges that are not actually the cause of the patient's pain. Relying solely on imaging studies to evaluate the source of low back pain carries a significant risk of diagnostic confusion because of the possibility of identifying a finding that was present before symptoms began, but which did not cause the symptoms. (Not explicitly stated is the risk that these findings will lead to an unnecessary intervention such as surgery.) Neither the patient's primary treater nor the consulting orthopedist has documented explicit neurologic findings that demonstrate specific nerve root compromise. The primary treater did not document any neurologic exam except for a positive straight leg raise, which is a nonspecific finding in the absence of documentation of what symptoms were produced and in what neurologic distribution. The consulting orthopedist documented an exam that is entirely lacking any signs of specific nerve root dysfunction, including negative bilateral straight leg raise, with normal sensation, strength and deep tendon reflexes in the lower extremities. The documented symptom of low back pain radiating to the buttock is common, and does not identify any specific nerve root involvement. Based on the MTUS and the medical records provided for my review, an MRI of the lumbar spine is not medically necessary. It is not medically necessary because its performance in the absence of documented findings of specific nerve root compromise is more likely to result in false positive findings and unnecessary interventions which may harm rather than help the patient. Therefore this request is not medically necessary.