

<b>Case Number:</b>	CM14-0140843		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	10/08/2013
<b>Decision Date:</b>	10/09/2014	<b>UR Denial Date:</b>	08/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/02/2014

### 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 North Carolina. 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:

The patient is a 58-year-old with a reported date of injury of 10/08/2013. The patient has the diagnoses of right shoulder sprain/strain, right shoulder contusion, right shoulder rotator cuff injury, lumbosacral sprain/strain, lumbosacral contusion, coccydynia, lumbosacral disc disease and possible right sacral wing occult fracture. The only progress notes provided for review come from the pain management physician dated 07/28/2014. On that date the patient had complaints of low back pain and right lower extremity pain. The patient had finished 8 sessions of electro-acupuncture. The physical exam noted lumbosacral tenderness to palpation with painful range of motion and positive straight leg raise test on the right. There is decreased sensation in the right L4/5 distribution. The right shoulder has tenderness to palpation with positive impingement sign and painful range of motion. Treatment recommendations included MRI of the lumbar spine and EMG of the bilateral lower extremities and continuation of medications.

### 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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, MRIs (magnetic resonance imaging)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 303-308.

**Decision rationale:** The ACOEM chapter on low back complaints and special diagnostics 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 as an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. 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. 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, computer 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. The patient has evidence of sensory deficits as noted in the physical exam. The patient has undergone acupuncture but no other conservative measures besides medications are noted in the progress notes. Table 12-8 states imaging should be reserved for cases where red flags are present on exam or cauda equina syndrome, tumor, infection or fracture are strongly suspected. There is also no mention of surgical consideration for treatment of the patient. For these reasons ACOEM guideline criteria have not been met. Therefore the request is not medically necessary and appropriate.