

Case Number:	CM15-0122546		
Date Assigned:	07/06/2015	Date of Injury:	10/13/2014
Decision Date:	07/31/2015	UR Denial Date:	06/05/2015
Priority:	Standard	Application Received:	06/25/2015

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 25-year-old female who sustained a work related injury October 13, 2014 after continuous lifting of heavy objects. According to a primary treating physician's progress notes, June 4, 2015, the injured worker presented with worsening bilateral low back pain and discomfort. She reports she is unable to ambulate without assistance and that the pain medication is not working. She denies numbness/tingling/weakness of the lower extremities or bladder and bowel changes. Physical examination revealed; 5'7" 205 pounds, thoracic back; normal range of motion, no tenderness, swelling, edema, or deformity, lumbar back; decreased range of motion, tenderness, bony tenderness and swelling. There is no edema, deformity or laceration. Pain is noted with forward flexion to 90 degrees, no pain with twisting, negative straight leg raise, no pain with hip range of motion, positive Fortin's and Faber's sign. She is able to sit without difficulty and walks with a normal gait. The physician further documents, she is unable to ambulate on own without assistance due to severe pain. Diagnoses are muscle spasm of the back; chronic low back pain; lumbar muscle strain. Treatment plan included restart Effexor, increase Zanaflex dose, consultation with orthopedics, and at issue, a request for authorization for an MRI lumbar.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI lumbar without contrast: Overturned

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

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

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. The patient has noted physiologic evidence of tissue insult and nerve impairment with worsening objective findings on exam. Therefore, criteria for MRI have been met and the request is medically necessary.