Case Number:	CM15-0123789		
Date Assigned:	07/08/2015	**Date of Injury:**	04/17/2015
Decision Date:	08/04/2015	**UR Denial Date:**	06/10/2015
Priority:	Standard	**Application Received:**	06/26/2015

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 (IW) is a 26 year old male who sustained an industrial injury on 04/17/2015. He reported a motor vehicle accident on the freeway where the worker was driving an automobile that was struck from behind. The injured worker was diagnosed as having cervical spine pain, and lumbar spine pain. Treatment to date has included medications, currently, the injured worker complains of neck and low back pain. The neck pain is resolved, but the moderate low back pain persists. The pain is located midline at the level of L5-S1. The pain is rated at a 7/10 intensity going down both legs, and was aggravated by lifting greater than 40 lbs. Relieving factors included rest, non-steroidal anti-inflammatory drugs and a flexible lumbar brace. The pain had worsened since last visit. On examination, the cervical spine exam was unremarkable. The lumbosacral spine had forward flexion to about 70 degrees with minimal discomfort. All other range of motion was normal and without discomfort. His gait was normal, and straight leg raise was normal. The treatment plan was for a MRI of the lumbar spine at 1.5 telsa or higher. A request for authorization is made for the following: MRI (Magnetic resonance imaging) Lumbar Spine, without contrast, (1.5 tesla or higher), outpatient.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI (Magnetic resonance imaging) Lumbar Spine, without contrast, (1.5 tesla or higher), outpatient: Upheld

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 inpatients 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. There is no recorded presence of emerging red flags on the physical exam. There is no evidence of significant nerve compromise on physical exam and there is not mention of consideration for surgery or complete failure of conservative therapy. For these reasons, criteria for imaging as defined above per the ACOEM have not been met. Therefore, the request is not medically necessary.