

Case Number:	CM15-0173320		
Date Assigned:	09/15/2015	Date of Injury:	06/08/2015
Decision Date:	10/15/2015	UR Denial Date:	08/07/2015
Priority:	Standard	Application Received:	09/02/2015

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 33 year old male with an industrial injury dated 06-08-2015. Medical record review indicates he is being treated for lumbar strain and radiculitis-lumbosacral. He presents on 06-24-2015 with lumbar pain that extended to right testes. Physical exam noted no tenderness to palpation of groin or testes. There was tenderness to right lumbar area with no inguinal or testicular tenderness. Neurovascular function was intact. Diagnostics as documented by the provider included lumbar spine 5 views x-rays: "No acute bony abnormality, but ill-defined radiopaque mass seen adjacent to right lumbar 4-sacral 1." Requested treatments included Cyclobenzaprine, Naproxen, physical therapy and x-rays. Work status was documented as "Return to modified work-activity today." He presented on 07-15-2015 for recheck with low back pain. The provider documents the injured worker was still having constant pain in the right lower lumbar back with occasional radiation to the groin. He had completed six physical therapy sessions. Physical exam noted no tenderness or bilateral muscle spasms of the lumbosacral spine. Range of motion was documented as full. Neurovascular function was intact with normal sensation. There was normal straight leg raising on the right and left and normal heel-toe gait. The treatment plan included physical therapy and MRI of lumbar spine. The provider documents "With persistence of radicular symptoms into the groin as well as constant lumbar pain after one month of conservative treatment, further imaging study (e.g. MRI) is needed to rule out disk origin of symptoms." The request for authorization dated 07-15-2015 is for lumbar MRI. On 08-07-2015 the request for lumbar MRI was denied by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar MRI: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

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. There is no recorded presence of emerging red flags on the physical exam. There is evidence of nerve compromise on physical exam but 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.