

Case Number:	CM15-0098074		
Date Assigned:	06/30/2015	Date of Injury:	02/11/2015
Decision Date:	07/29/2015	UR Denial Date:	05/12/2015
Priority:	Standard	Application Received:	05/21/2015

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 who sustained an industrial injury on 2/11/15 to his low back as he was carrying a 90 pound toilet up stairs. He felt immediate pain in the lower back. He was medically evaluated, given medications, back brace and x-rays of his back were done. He currently complains of intermittent low back pain. His pain level is 7/10. He has difficulty with activities of daily living involving self-care and personal hygiene, physical activities such as prolonged standing, sitting, walking, and sleep difficulties. On physical exam of the lumbar spine, there was diffuse tenderness and spasms at L4 to the sacrum. There was pain with range of motion. Medications are Tramadol and naproxen. Diagnoses include protrusions at T7-8 and T8- 9 with ventral impression on the thecal sac and possible myelomalacia; myoligamentous sprain/ strain of the lumbosacral spine, superimposed on multi-level diffused degenerative disc disease with a bulge at L5-S1. Treatments to date include physical therapy; chiropractic manipulation; medication. Diagnostics include MRI of the lumbar spine (4/10/15) showing degenerative changes, annular bulge at L5-S1; MRI of the thoracic spine (4/10/15) showing protrusions at T7- 8 and T8-9; x-ray of the lumbar spine (4/24/15) showing degenerative changes; x-rays of the thoracic spine (4/24/15) showing protrusions. In the progress note dated 4/24/15, the treating provider's plan of care includes a request for repeat MRI of the thoracic and lumbar spine to rule out protrusions as well as cord irritation.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI chest spine without dye: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Indications for Imaging, (Magnetic Resonance Imaging).

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

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. There are no significant physical changes since last MRI. For these reasons, criteria for imaging as defined above per the ACOEM have not been met. Therefore, the request is not medically necessary.