

Case Number:	CM14-0001387		
Date Assigned:	01/22/2014	Date of Injury:	08/24/2011
Decision Date:	09/25/2015	UR Denial Date:	12/17/2013
Priority:	Standard	Application Received:	01/03/2014

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. 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: Texas, Florida, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 52 year old female with an August 24, 2011 date of injury. A progress note dated November 4, 2013 documents subjective complaints (worsening neck pain rated at a level of 7 out of 10; bilateral shoulder pain rated at a level of 7 out of 10; worsening lower back pain rated at a level of 7 out of 10; right knee pain rated at a level of 7 out of 10; increased radicular symptoms in the upper and lower extremities), objective findings (decreased left grip strength; pain with active range of motion of the cervical spine; positive foraminal compression test bilaterally; decreased range of motion of the left shoulder; decreased sensation in the right C6 dermatome; decreased sensation in the L5 and S1 dermatomes in the right), and current diagnoses (cervical disc syndrome; lumbar spine herniated nucleus pulposus; right knee chondromalacia patella; right knee internal derangement). Treatments to date have included medications, physical therapy, and cortisone injection to the right knee, imaging studies, and surgery. The treating physician documented a plan of care that included magnetic resonance imaging of the lumbar spine without contrast.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) MRI of the lumbar spine without contrast: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM <https://www.acoempracguides.org/low-back>; Table 2, Summary of Recommendations, Low Back Disorders.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): American College of Occupational and Environmental Medicine Page 303, Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back.

Decision rationale: This claimant was injured four years ago. There is still neck, shoulder and back pain. There is reported longstanding decreased sensation in the L5 and S1 dermatomes in the right. There is no documentation however of progression of neurologic findings. Diagnoses include cervical disc syndrome; lumbar spine herniated nucleus pulposus; right knee chondromalacia patella; and right knee internal derangement. Under MTUS/ACOEM, although there is subjective information presented in regard to increasing pain, there are little accompanying changes or evolution/progression of physical signs. Even if the signs are of an equivocal nature, the MTUS note that electrodiagnostic confirmation generally comes first. They note "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". The guides warn that 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. I did not find electrodiagnostic studies. It can be said that ACOEM is intended for more acute injuries; therefore other evidence-based guides were also examined. The ODG guidelines note, in the Low Back Procedures section: Lumbar spine trauma: trauma, neurological deficit, Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit), Uncomplicated low back pain, suspicion of cancer, infection, Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. (For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383.) (Andersson, 2000) Uncomplicated low back pain, prior lumbar surgery, uncomplicated low back pain, cauda equina syndrome. These criteria are also not met in this case. The request was appropriately non-certified under the MTUS and other evidence-based criteria and therefore is not medically necessary.