Case Number:	CM16-0236134		
Date Assigned:	12/12/2016	**Date of Injury:**	10/24/2016
Decision Date:	01/10/2017	**UR Denial Date:**	11/28/2016
Priority:	Standard	**Application Received:**	12/08/2016

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 was a 31 year old male, who sustained an industrial injury on October 24, 2016. The injured worker was undergoing treatment for strain of muscle, fascia and tendon of the lower back subsequent encounter. According to progress note of November 16, 2016, the injured worker's chief complaint was worsening back pain. The injured worker was working modified duty and tolerating current medications. The injured worker described the symptoms as dull and moderately severe. The pain was aggravated by lifting. The symptoms were lessened by rest. The injured worker complained of limited back motion and weakness in the leg. The objective findings were the injured worker was alert and oriented times 3. The injured worker's mood and affect wear appropriate. The injured worker had a normal gait and full weight bearing on both lower extremities. There was no weakness in the lower extremities. There were no spasms of the thoracolumbar spine and paravertebral musculatures. There was tenderness of the thoracolumbar spine. The range of motion of the back was restricted. The flexion with the fingertips was approximately of the mid-thigh. The stimulation was intact to light touch and pinprick in all dermatomes of the bilateral lower extremities. The straight leg raises were positive on the left at 30 degrees. The back muscles displayed no weakness. The injured worker previously received the following treatments 6 sessions of physical therapy for the thoracic and lumbar spine, Cyclobenzaprine, Tramadol, Ketoprofen and 6 sessions of chiropractic services. The RFA (request for authorization) dated November 17, 2016; the following treatments were requested an MRI of the lumbar spine. The UR (utilization review board) denied certification on November 28, 2016; for an MRI of the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Indications for imaging-Magnetic resonance imaging.

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.