MAXIMUS Federal Services

Case Number:	CM14-0193297		
Date Assigned:	12/01/2014	Date of Injury:	12/06/1994
Decision Date:	01/13/2015	UR Denial Date:	10/28/2014
Priority:	Standard	Application Received:	11/18/2014

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. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in North Carolina. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 51-year-old with a reported date of injury of 03/31/1999. The patient has the diagnoses of failed back surgery syndrome, back pain and Bell's palsy. Per the progress notes provided for review from the primary treating physician dated 10/17/2014, the patient had complaints of pain in the back and new tingling in the left groin and top of the thigh. The psychical exam noted absence of deep tendon reflexes in the knee and ankles, weakness 3/5 with left hip flexion and left ankle dorsiflexion and decreased sensation across the lateral left calf and dorsum of the foot. Treatment plan recommendations included second opinion orthopedic consult, lumbar MRI, acupuncture and oral medications. Previous treatment modalities have included lumbar hemi laminectomy and discectomy and acupuncture. Lumbar MRI performed on 06/19/2014 noted slight improvement in the bony edema and epidural component of the discitis and osteomyelitis with persistent and significant enhancement from the apparent active infection at the L2/3 disc space.

IMR ISSUES, DECISIONS AND RATIONALES

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

One MRI of the lumbar spine with and without contrast: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 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 orderingan 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 surgeryis 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. The requested MRI per the documentation is for new left lower extremity radicular symptoms and that the second opinion orthopedic consults would want an updated MRI. The patient complained of new tingling in the left groin and upper thigh for one week. The physical exam noted no sensation or neurologic deficits in this area. The patient just underwent MRI in 06/2014. The physical exam failed to show new unequivocal objective findings of specific nerve compromise. Therefore criteria have not been met for lumbar MRI per the ACOEM and the request is not medically necessary.