

Case Number:	CM15-0139714		
Date Assigned:	07/29/2015	Date of Injury:	05/12/2014
Decision Date:	08/26/2015	UR Denial Date:	07/11/2015
Priority:	Standard	Application Received:	07/20/2015

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 30 year old female who sustained an industrial injury on 05/12/2014. Mechanism of injury occurred while pulling a pallet jack. Diagnoses include displacement of lumbar disc without myelopathy. Treatment to date has included diagnostic studies, medications, physical therapy, chiropractic sessions and an epidural injection without significant relief of symptoms. A Magnetic Resonance Imaging of the lumbar spine on 09/16/2014 revealed L3-4 central focal disc protrusion that abuts the thecal sac, foramina were patent, and at L5-S1 there was a left paracentral disc protrusion that abutted the thecal sac with spina and foraminal narrowing. A physician progress note dated 06/11/2015 documents the injured worker complains of low back pain which radiated into both buttocks and is associated with numbness and tingling sensation in the left great toe. She rates her pain as 8-9 out of 10. She can only walk several blocks, but must walk slowly. She has difficulty sleeping due to pain, and she feels her pain is worsening. Examination reveals tenderness at the L5-S1 level. The straight leg raising test and bowstring sign produce back pain. On 06/24/2015 a physician progress note documents the injured worker has been unresponsive to conservative treatment. The treatment plan includes a recommendation for surgery for disc replacement arthroplasty. Treatment requested is for a Magnetic Resonance Imaging of the lumbar spine without dye.

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 without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

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 inpatients 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.