MAXIMUS Federal Services

Case Number:	CM15-0147644		
Date Assigned:	08/10/2015	Date of Injury:	05/02/1996
Decision Date:	09/04/2015	UR Denial Date:	07/08/2015
Priority:	Standard	Application Received:	07/29/2015

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 55-year-old female, who sustained an industrial injury on 5-2-96. Initial complaints were not reviewed. The injured worker was diagnosed as having lumbago with left leg sciatica. Treatment to date has included physical therapy; aquatic therapy; medications. Currently, the PR-2 notes dated 6-25-15 indicated the injured worker complains of low back pain, left leg pain and numbness. The provider documents she is currently experiencing low back pain and left leg numbness along the L4 distribution and has increased over the last 4 months. She has increased numbness and now weakness down the left leg. Due to the change in her condition, he is requesting a MRI for further evaluation of her condition. He notes this was denied on 6-18-15. He reports the injured worker has undergone conservative treatment including physical therapy, epidural injections without resolve of her condition. She has a surgical history for two left foot surgeries in 1997 and the right foot in 1997. On physical examination, the provider documents lumbar spine pain with direct palpation at the bilateral L4-5 and L5-S1 facets, straight leg raising on the left is positive at 80 degrees, negative on the right. She has decreased sensation to touch along the L4-5 dermatomes. He remarks in his treatment plan that aquatic therapy remains unauthorized. The provider is requesting authorization of an updated MRI 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 lumbar spine MRI without contrast: Upheld

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

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 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.