

Case Number:	CM15-0169609		
Date Assigned:	09/10/2015	Date of Injury:	10/12/2007
Decision Date:	10/07/2015	UR Denial Date:	07/30/2015
Priority:	Standard	Application Received:	08/28/2015

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 56 year old female, who sustained an industrial-work injury on 10-12-07. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar radiculitis, degeneration of lumbar intervertebral disc, and lumbar foraminal stenosis. Medical records dated (12-5-14 to 7-23-15) indicate that the injured worker complains of persistent low back and right buttocks with right leg pain. The pain is shooting and tingling that goes down to the right foot. The pain is rated 3 to 8 out of 10 on pain scale. Per the treating physician report dated 7-23-15 the employee may continue to work full duty without restrictions. The physical exam dated from (12-5-14 to 7-23-15) reveals that the lumbar exam shows that there is tenderness to palpation in the right lower lumbar paraspinals. The lumbar range of motion shows flexion is 75 percent of normal, extension is 50 percent of normal right oblique extension- with pain. The lumbar spinous processes Spring test causes back pain, the dural stretch test was positive in right L5 distribution, slump test causes right buttock pain and supine leg raise causes right buttock pain. Treatment to date has included pain medication, diagnostics, back brace, hot and cold packs, physical therapy (unknown amount of sessions), 2 steroid injections around 2013 and yoga. The medical record dated 7-23-15 the physician refers to a Magnetic Resonance Imaging (MRI) of the lumbar spine dated 11-2009 that he writes shows "diffuse disc bulges at lumbar 4-5 and lumbar 5 and S1 impinging bilateral nerve roots at both lumbar 4 and 5 and lumbar 5 and S1." The original Utilization review dated 7-30-15 denied a request for Magnetic Resonance Imaging (MRI) of the Lumbar spine without Contrast to evaluate for right lumbar 5 radiculopathy as the injured worker has no significant neurological deficits or findings consistent with significant specific nerve compromise and therefore, not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI (magnetic resonance imaging), Lumbar spine without Contrast: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

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.