MAXIMUS Federal Services

Case Number:	CM15-0191836		
Date Assigned:	10/06/2015	Date of Injury:	12/20/2014
Decision Date:	11/12/2015	UR Denial Date:	09/23/2015
Priority:	Standard	Application Received:	09/30/2015

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 58 year old female who sustained an industrial injury on 12-20-2014. A review of medical records indicates the injured worker is being treated for lumbar disc protrusion and L1 and L2 compression fracture. Medical records dated 8-31-2015 noted low back pain rated a 9 out of 10. Since her last visit, she was feeling worse. She also complained of neck, upper, and mid back, and bilateral leg pain rated a 9 out 10 as well as headaches, bilateral shoulder and feet pain rated an 8 out of 10. She has attended 6 sessions of physical therapy with increase in her pain. She was taking less amount of medication than before. She is currently on modified work duties. Physical examination noted there was tenderness to palpation noted over the paraspinal region. Straight leg raise test was positive. Range of motion lacked 10 degrees in all planes. MRI of the lumbar spine dated 6-18-2015 at T12L1 there is a 4mm broad based posterior disc protrusion. EMG-NCV of the bilateral lower extremities dated 6-2015 noted consistent with chronic bilateral L4-5 radiculopathy. Treatment has included physical therapy and medications. Utilization review form dated 9-23-2015 noncertified x-ray of the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-ray of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Diagnostic Criteria.

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.