MAXIMUS Federal Services

Case Number:	CM15-0198674		
Date Assigned:	10/14/2015	Date of Injury:	03/04/2015
Decision Date:	11/20/2015	UR Denial Date:	09/04/2015
Priority:	Standard	Application Received:	10/09/2015

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:

This is a 40 year old female who sustained a work-related injury on 3-4-15. Medical record documentation on 8-25-15 revealed the injured worker was being treated for lumbar spine sprain-strain and bilateral lower extremities radiculopathy. She reported low back pain and noted that the pain intensifies at night. She rated her pain a 6 on a 10-point scale. Objective findings included lumbar spine range of motion of flexion to 42 degrees, extension to 25 degrees, right flexion to 19 degrees and left flexion to 21 degrees. Bilateral sacroiliac joint range of motion included on the flexion to 40 degrees on the left and 42 degrees on the right, extension to 20 degrees on the left and 15 degrees on the right, internal rotation to 20 degrees on the left and 22 degrees on the right, external rotation to 18 degrees on the left and 21 degrees on the right. She had 2+ tenderness over the lumbar spine paravertebral region and 3+ tenderness over the right piriformis muscle. She has 2+ tenderness to palpation over the posterior sacroiliac spine region bilaterally. A sacroiliac joint test was +3. She reported pain with internal rotation and external rotation of the right lower extremity. The evaluating physician noted that an MRI of the lumbar spine was needed to rule out disc pathology. Previous therapy included 8 sessions of physical therapy of which the first six were ineffective. A request for MRI of the lumbar spine was received on 8-28-15. On 9-4-15, the Utilization Review physician determined MRI of the lumbar spine was 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) of the lumbar spine, quantity: 1: Upheld

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

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.