

Case Number:	CM15-0087139		
Date Assigned:	05/11/2015	Date of Injury:	11/19/2005
Decision Date:	06/19/2015	UR Denial Date:	04/09/2015
Priority:	Standard	Application Received:	05/07/2015

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 11/19/2005. She reported that something fell on her left leg and pinned her against a wall. The injured worker was diagnosed as having discogenic lumbar condition with magnetic resonance imaging showing facet changes at L4-5 and bulging at L4-5 (now 3 years old), hip joint inflammation, especially on the left with magnetic resonance imaging showing bursitis, hip joint inflammation on the right with no diagnostics, and sleep and stress element due to chronic pain and inactivity. Treatment to date has included diagnostics, acupuncture, physical therapy, transcutaneous electrical nerve stimulation unit, back brace, and medications. Currently, the injured worker complains of pain in her left buttock and right groin. She reported sudden intense pain that she gets which almost makes her fall in the back region. She was documented as falling at a rate of maybe six times a year, last in 11/2014. Physical exam noted lumbosacral tenderness and reduced sensory along the L5-S1 dermatome on the left, with some weakness to resisted function noted along the lower extremities on the left. The treatment plan included magnetic resonance imaging of the lumbar spine to evaluate for disease progression and magnetic resonance imaging of the right hip. A progress report, dated 11/04/2014, also noted complaints of instability and falling.

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.

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 certified.