MAXIMUS Federal Services

Case Number:	CM15-0092219		
Date Assigned:	05/18/2015	Date of Injury:	03/08/2013
Decision Date:	06/18/2015	UR Denial Date:	05/07/2015
Priority:	Standard	Application Received:	05/13/2015

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 54-year-old, female who sustained a work related injury on 3/8/13. While working, she had a heavy metal stand fell on her hitting right side of head and right shoulder. She fell to the ground with ironing stand on top of her. She states the stand weighs about 85 pounds. She lost consciousness for about a minute after she fell and she lost control of bladder after she fell. The diagnoses have included lumbar disc herniations with neural foraminal narrowing and lumbar facet arthropathy. Treatments have included medications, ice/heat therapy, home exercises, and 24 physical therapy sessions, including TENS unit therapy. In the Doctor's First Report of Occupational Injury or Illness dated 4/27/15, the injured worker complains of increased pain at work. She continues to have persistent bowel and bladder incontinence. She states she has worsening numbness in her groin region. She continues to work full duty. She complains of continued low back pain. She rates her lower back pain level a 7/10. She complains of radiating pain, numbness and tingling in her left leg. She has decreased range of motion in lumbar spine. The treatment plan includes a request for an updated MRI of lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Spine MRI: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation ACOEM Chapter 7, Independent Medical Evaluations and Consultations, page 503. Official Disability Guidelines, Treatment Index, 13th Edition (web) 2015, Low Back, MRIs, Neck and Upper Back, Magnetic resonance Imaging (MRI).

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 clinical documentation provided for review meets criteria for lumbar MRI as outlined above per the ACOEM. Therefore, the request is medically necessary.