

Case Number:	CM15-0095891		
Date Assigned:	05/22/2015	Date of Injury:	03/05/2009
Decision Date:	06/24/2015	UR Denial Date:	04/30/2015
Priority:	Standard	Application Received:	05/18/2015

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 3/05/2009, due to cumulative trauma from data entry. The injured worker was diagnosed as having carpal tunnel syndrome, and lumbar sprain. Treatment to date has included diagnostics, left wrist surgery in 2011, right wrist surgery in 2012, mental health treatment, and medications. Currently (4/16/2015), the injured worker complains of shoulder, hand, and back injury. Her left leg gave out two weeks earlier, and she fell. She was getting pain in her left leg since, with numbness and intermittent weakness. Her lumbar spine pain was rated 2/10 at the least and 6/10 at worst. The duration was chronic since injury in 2009. Her pain radiated to the coccyx, groins, buttocks, and legs, left greater than right. Current medications included Vicoprofen, Advil, and Lisinopril. Exam of the lumbar spine noted tenderness along the pelvic brim and decreased range of motion. Heel and toe walk was normal and deep tendon reflexes in the pre-patellar and Achilles areas were normal and equal bilaterally. Percussion of the left Achilles tendon caused pain, bringing her to tears. Neurosensory function was a bit lessened on the left outer leg when compared to the right. She reported left leg weakness for several months. Magnetic resonance imaging of the lumbar spine (2013) was documented as showing some joint space narrowing. The magnetic resonance imaging report was not submitted. The treatment plan included updated magnetic resonance imaging of the lumbar spine, open secondary to claustrophobia.

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: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, 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 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.