

Case Number:	CM13-0057730		
Date Assigned:	12/30/2013	Date of Injury:	12/24/2009
Decision Date:	03/27/2014	UR Denial Date:	11/18/2013
Priority:	Standard	Application Received:	11/25/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation; has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 65 year-old male with a date of date of industrial injury on December 24, 2009. The injury occurred when the patient was pushed by a work associate and fell over a pallet. The current diagnoses are: multilevel lumbar degenerative disc disease; lumbar facet syndrome, rule out neurogenic claudication. There is a request for a vascular Doppler of the lower extremity and a lumbar spine MRI. The patient's past medical history includes hypertension, high cholesterol, history of avid tobacco use, alcohol use, gout, GERD, obstructive sleep apnea, diverticulitis, coronary artery disease, diabetes mellitus, BPH and also history of TIA. A 10/31/13 office visit with the primary treating physician states that the patient is still having difficulty with prolonged standing, walking and ambulation with both backache and bilateral leg pain and associated weakness. The patient also states he had previous open heart surgery and is on some medications. There was a question of whether he has true neurogenic claudicating. He was sent back through his future medical care to be treated. There is an issue that he may also have a problem with vascular claudicating. On physical examination dated 10/31/13 there is focal tenderness along the L3-4, L4-5 and L5-S1 posterior spinous processes and paraspinal muscles bilaterally. On range of motion, the patient stands in an upright position and forward flexes with his hands to about his mid-tibias. He uses a mild upper extremity assist to come to an upright position. Extension is limited to 5 degrees with pain into both glutei regions. Right and left lateral bending are equal and symmetric to about 5 degrees. The patient shows no focal neurological deficit, L2 through S1, to motor and sensory evaluation except for some decreased sensation in a stocking glove distribution to his feet. The patient has trace dorsalis pedis and posterior tibial pulses and a trace popliteal pulse. The reflexes of the patellae and the Achilles are full and symmetric and 2+ bilaterally. Diagnostic studies reveal that the patient's 2011 lumbar

spine MRI shows multilevel lumbar degenerative disc disease with 3-mm disc protrusions at L3-4 and L4-5 and some facet arthropathy, but no evidence of stenosis . A 7/27/11 primary treating physician report indicates that the patient's posterior tibial and dorsalis pedis pulses are 2+ bilaterally. There is documentation that patient had electrodiagnostic studies on a 4/3/12 report which indicates that there is electrodiagnostic evidence of chronic right L5 radiculopathy. An MRI Study of the Lumbar Spine dated 4/12/12 indicated multi level facet hypertrophy, neural foraminal stenosis, probably arteriosclerotic change to the abdominal aorta.

IMR ISSUES, DECISIONS AND RATIONALES

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

Vascular doppler lower extremity: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation CA MTUS 2009 American College of Occupational and Environmental Medicine (ACOEM) and Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACR Appropriateness Criteria® claudication -- suspected vascular etiology. Bibliographic Source(s) Dill KE, Rybicki FJ, Desjardins B, Flamm SD, Francois CJ, Gerhard-Herman MD, Kalva SP, Mansour MA, Mohler ER III, Oliva IB, Schenker MP, Weiss C, Expert Panel on

Decision rationale: The Physician Reviewer's decision rationale: Vascular Doppler lower extremity is medically necessary per the ACR Appropriateness Criteria for claudication -- suspected vascular etiology. The MTUS and ODG are silent on this specific issue. The ACR Appropriateness Criteria for suspected vascular claudication states a duplex ultrasound (US) of the extremities can be used to diagnose the location, degree, and extent of stenosis to the level of the knee. In patients who do not have demonstrable arterial disease, imaging studies of other systems such as the lumbar spine or soft-tissues of the pelvis may be indicated. Furthermore, most patients with peripheral arterial occlusive disease are asymptomatic; as few as 6% to 20% of such patients will have symptoms of claudication. The documentation indicates that patient has evidence on recent examination of decreased peripheral pulses as compared to a physical examination in 2011. He has complaints of pain, weakness, paresthesias in his legs. Patient has many risk factors for vascular claudication including coronary artery disease, history of TIA, hyperlipidemia, hypertension, history of smoking, as well as probable arteriosclerotic changes on abdominal aorta as seen on lumbar MRI A vascular Doppler of the lower extremity is medically appropriate and reasonable.

Lumbar spine MRI: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation CA MTUS 2009 American College of Occupational and Environmental Medicine (ACOEM).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 303.

Decision rationale: The Physician Reviewer's decision rationale: Lumbar spine MRI is not medically necessary per MTUS guidelines. The ACOEM guidelines recommend imaging studies when there are unequivocal objective findings that identify specific nerve compromise on the neurologic examination for patients who do not respond to treatment and who would consider surgery as an option. On documentation patient has some decreased sensation in a stocking distribution but otherwise strength and reflexes are intact. Additionally, elsewhere in this review a lower extremity vascular Doppler was recommended to evaluate for possible vascular pathology causing patient's claudication type symptoms. The ACR Appropriateness Criteria for vascular imaging states that patients who do not have demonstrable arterial disease, imaging studies of other systems such as the lumbar spine may be indicated. Due to the fact that there are no objective findings that identify specific nerve compromise on physical examination and that vascular pathology is being evaluated first a lumbar spine MRI at this point is not medically necessary or appropriate.