

Case Number:	CM14-0169199		
Date Assigned:	10/17/2014	Date of Injury:	01/01/2003
Decision Date:	11/19/2014	UR Denial Date:	09/30/2014
Priority:	Standard	Application Received:	10/14/2014

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in Arizona. 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/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:

This 73-year old female working for a winery, sustained an injury [not well documented] in 1990, affecting her cervical spine, right shoulder and right arm. She was followed by a second injury to her right knee in 1998. She returned to part-time work but led to cumulative trauma in 2003 and led to symptoms in her right shoulder, lumbar spine and right knee. Official date of injury was 1/1/2003 [un-specified]. She has continued complaints of severe low back pain [8-9/10], radiating left lower extremity pain [9/10] radiating to 'mid fore leg' and paraesthesia to 'mid fore leg'. Caregiver admitted on 6/3/2014 that conservative care failed and suggested epidural steroidal injection (ESI) and orthopedic spine consult. Physical examination [8/14/2016] revealed low back motion decreased and painful and non-healing ulcer left 'fore' leg. Motor findings were normal and symmetrical [reported on 6/3/2014 as 4/5 strength hip flexion and knee extension.] Sensation was not documented and straight leg raise only produced discomfort at 80 degrees [40 degrees on 6/3/2014][60 degrees]. Patella reflex was reported as 1+ and other lower extremity reflexes 2+ and symmetrical. On occasion, she also complained of bilateral groin pain. Treatment rendered since day of injury:- Ice packs- Prescribed a single point cane- Prescribed exercises [No documented detail]- Home exercise program [HEP]- Medication [did not help for leg pain]o Norcoo Gabapentino Metoprololo Doxepino Ibupropheno Lidoderm patches- Right knee arthroplastyDiagnostic studies consisted of:- Urine toxicology screening [6/18/2014]- MRI in 2011. [Report not available.]Diagnosis was documented as: o Cervicalgia 723.1o Chronic pain syndrome 338.4o Lumbago 724.2o Pain in shoulder joint area 719.41o Pain in the pelvic jointRecommendations:- Authorization for MRI of the lumbar spine- Orthopedic spine consult [approved 6/12/2014] for possible epidural spinal injection [ESI].- ESI [6/3/2014]-MRI suggested UR denial date was 9/30/2014UR denial of MRI of the lumbar spine.

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 Chapter, Magnetic Resonance Imaging (MRIs) Section

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Fig 12.8 Page(s): 303 and 360 of 611.

Decision rationale: There is a lack of improvement after 6 weeks of conservative therapy is stated as an important red flag to initiate further studies e.g. MRI of the lumbar spine. It may be appropriate to order MRI lumbar study if the caregiver is of the opinion that it could aid in patient's clinical management. There is no documentation of adequate conservative care for her back and leg pain to initiate a MRI study of the lumbar spine. No conventional 'red flag criteria' were present [see below] in this patient's course. This patient actually showed functional improvement in documentation up to her last follow-up [9/16/2014]. The following table outlines red flags as discussed. RED FLAGS: Minor trauma in patients older than age 50 years. Significant trauma in all patients Unexplained fever in all patients Recent urinary infection diagnosed; Any skin infection or penetrating wound near the spine Occurrence of unremitting night pain or pain at rest. Progressive or disabling neurologic deficit (e.g. 'saddle' anesthesia, bilateral sciatica, bilateral leg weakness, difficulty urinary voiding and fecal incontinence) Unexplained weight loss History or strong suspicion of cancer Osteoporosis UNDERLYING Chronic steroid use Immunosuppression DISEASE OR STATUS Intravenous drug abuse at present Lack of improvement after 6 weeks of conservative therapy Imaging studies should be used as confirmation studies once a working diagnosis [pain generator] is determined. MRI can be too sensitive with regard to degenerative disease findings and commonly displays pathology that is not responsible for the patient's symptoms [false-positive findings]. MRI 's of the lumbar spine is also associated with a high rate of abnormal findings in asymptomatic individuals. Kinkadein in 2007 found herniated disks on magnetic resonance imaging in 9% to 76% of asymptomatic patients; bulging disks, in 20% to 81%; and degenerative disks, in 46% to 93%. As this will be a repeat MRI [MRI was done in 2011], we will need previous report for comparison. As a point of interest it should be noted that the use of lumbar MRI increased by 307% during a recent 12-year interval. When judged against guidelines, one-third to two-thirds of spinal computed tomography imaging and MRI may be inappropriate. (Deyo, 2009) ODG reminds that imaging is indicated only if patient presents severe progressive neurologic impairments or signs or symptoms indicating a serious or specific underlying condition [red flag], or if they are candidates for invasive interventions. Immediate imaging is recommended for patients with major risk factors for cancer, spinal infection, cauda equina syndrome, or severe or progressive neurologic deficits. Imaging after a trial of conservative treatment is recommended for patients who have minor risk factors for cancer, inflammatory disease, vertebral compression fracture, radiculopathy, or symptomatic spinal stenosis. No history of progressive neurologic deficit, prior lumbar surgery, cauda equina syndrome or myelopathy is present. Low back pain accompanied by radiculopathy [after adequate conservative care] is also accepted as indication for MRI. This patient does not present true radiculopathy. At the time of his last follow-up [8/4/2014], he presented symmetrical lower extremity motor strength, 'positive' straight leg raise [SLR] at 80 degrees [previously 40 degrees] bilaterally and no documentation of sensory status. Non-specific low back pain with undocumented radiculopathy, once again,

does not necessitate MRI of the lumbar spine in this patient.