

<b>Case Number:</b>	CM14-0053379		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	03/26/2014
<b>Decision Date:</b>	08/28/2014	<b>UR Denial Date:</b>	04/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/22/2014

### 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 Physical Medicine & Rehab and is licensed to practice in California. 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 58 year-old patient sustained a low back injury on 3/26/14 when he slipped while descending a ladder with leg stuck in ladder from employment by [REDACTED]. Request under consideration include ortho spine referral and MRI lumbar spine. Diagnoses include lumbar region sprain; back disorder; and knee/leg sprain NOS. Report of 4/4/14 from the provider noted patient stating physical therapy and medication not help with pain. Exam showed neurological exam unchanged with antalgic gait(no objective findings detailed). The patient was taking six hydrocodone/day without relief and was changed to Percocet. Retroactive physical therapy of 6 sessions was certified. There is an MRI report dated 5/22/14 noting patient with history of melanoma in 2005. Results were compared to study of 7/7/2008 with findings of multi-level disc bulges of 3-5 mm slightly increased with some neural foraminal narrowing and canal stenosis. Report of 7/11/14 from the provider noted the patient had orthopedic evaluation on 7/7/14 and MRI was reviewed and opined future surgery only as the last resort with recommendation for conservative care. Report of 7/24/14 from pain management noted the patient with chronic low back pain radiating to right lower extremity rated at 7/10 without medications. Exam showed antalgic gait; decreased sensation at L4-S1; spasm; tenderness; and decreased lumbar flex/ext (no degree specified). Diagnoses include lumbosacral radiculopathy; right knee tendinitis/bursitis; and lumbar sprain/strain. Treatment included epidural steroid injections, Norco, and TTD status continued. The request for ortho spine referral and MRI lumbar spine were non-certified on 4/14/14 citing guidelines criteria and lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ORTHO SPINE REFERRAL:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES:CHAPTER LOW BACK , WEB EDITION.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305.

**Decision rationale:** This 58 year-old patient sustained a low back injury on 3/26/14 when he slipped while descending a ladder with leg stuck in ladder from employment by [REDACTED]. Request under consideration include ortho spine referral and MRI lumbar spine. Diagnoses include lumbar region sprain; back disorder; and knee/leg sprain NOS. Report of 4/4/14 from the provider noted patient stating physical therapy and medication not help with pain. Exam showed neurological exam unchanged with antalgic gait(no objective findings detailed). The patient was taking six hydrocodone/day without relief and was changed to Percocet. Retroactive PT of 6 sessions were certified. There is an MRI report dated 5/22/14 noting patient with history of melanoma in 2005. Results were compared to study of 7/7/2008 with findings of multi-level disc bulges of 3-5 mm slightly increased with some neural foraminal narrowing and canal stenosis. Report of 7/11/14 from the provider noted the patient had orthopedic evaluation on 7/7/14 and MRI was reviewed and opined future surgery only as the last resort with recommendation for conservative care. Exam showed negative SLR at 90 degrees; tenderness to palpation of paravertebral area; limited range in all planes; negative Faber's DTRs 2+ symmetrical; motor strength of 5/5 throughout bilateral lower extremities; and decreased sensation of lateral posterior calves. Diagnoses were lumbosacral sprain/strain with radiculopathy; bilateral knee tendinosis; history of left shoulder surgery; hypertension; and history of melanoma. Report of 7/24/14 from pain management noted the patient with chronic low back pain radiating to right lower extremity rated at 7/10 without medications. Exam showed antalgic gait; decreased sensation at L4-S1; spasm; tenderness; and decreased lumbar flex/ext (no degree specified). Diagnoses include lumbosacral radiculopathy; right knee tendinitis/bursitis; and lumbar sprain/strain. Treatment included epidural steroid injections, Norco, and TTD status continued. The request for ortho spine referral and MRI lumbar spine were non-certified on 4/14/14. Submitted reports have not demonstrated any surgical lesion or indication for surgical consult. Examination has no specific neurological deficits to render surgical treatment nor is there any diagnostic study remarkable for any surgical lesion. Guidelines support surgical consultation for the purpose of clarification of the treatment plan and diagnosis when there are presentations of persistent, severe and disabling symptoms with red- flag conditions identified to suggest possible instability, failure to increase in range in therapy with extreme progression of symptoms, and neurological deficits of muscular strength and specific sensory loss to suggest a surgical lesion that is imaging confirmed. Submitted reports have not adequately demonstrated support for all criteria for this orthopedic consultation. The ortho spine referral is not medically necessary and appropriate.

**MRI LUMBAR SPINE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, INDICATIONS FOR IMAGING.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

**Decision rationale:** This 58 year-old patient sustained a low back injury on 3/26/14 when he slipped while descending a ladder with leg stuck in ladder from employment by [REDACTED]. Request under consideration include ortho spine referral and MRI lumbar spine. Diagnoses include lumbar region sprain; back disorder; and knee/leg sprain NOS. Report of 4/4/14 from the provider noted patient stating physical therapy and medication not help with pain. Exam showed neurological exam unchanged with antalgic gait(no objective findings detailed). The patient was taking six hydrocodone/day without relief and was changed to Percocet. Retroactive PT of 6 sessions were certified. There is an MRI report dated 5/22/14 noting patient with history of melanoma in 2005. Results were compared to study of 7/7/2008 with findings of multi-level disc bulges of 3-5 mm slightly increased with some neural foraminal narrowing and canal stenosis. Report of 7/11/14 from the provider noted the patient had orthopedic evaluation on 7/7/14 and MRI was reviewed and opined future surgery only as the last resort with recommendation for conservative care. Exam showed negative SLR at 90 degrees; tenderness to palpation of paravertebral area; limited range in all planes; negative Faber's DTRs 2+ symmetrical; motor strength of 5/5 throughout bilateral lower extremities; and decreased sensation of lateral posterior calves. Diagnoses were lumbosacral sprain/strain with radiculopathy; bilateral knee tendinosis; history of left shoulder surgery; hypertension; and history of melanoma. Report of 7/24/14 from pain management noted the patient with chronic low back pain radiating to right lower extremity rated at 7/10 without medications. Exam showed antalgic gait; decreased sensation at L4-S1; spasm; tenderness; and decreased lumbar flex/ext (no degree specified). Diagnoses include lumbosacral radiculopathy; right knee tendinitis/bursitis; and lumbar sprain/strain. Treatment included epidural steroid injections, Norco, and TTD status continued. ACOEM Treatment Guidelines for the Lower Back Disorders, under Special Studies and Diagnostic and Treatment Considerations, states Criteria for ordering imaging studies include Emergence of a red flag; Physiologic evidence of tissue insult or neurologic dysfunction; Failure to progress in a strengthening program intended to avoid surgery; Clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination and electrodiagnostic studies. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist; however, review of submitted medical reports have not adequately demonstrated the indication for MRI of the Lumbar spine nor document any failed conservative trial with medications and therapy. When the neurologic examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study, not evident here. The MRI lumbar spine is not medically necessary and appropriate.