

<b>Case Number:</b>	CM14-0067989		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	06/01/1990
<b>Decision Date:</b>	12/17/2014	<b>UR Denial Date:</b>	04/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/12/2014

### 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 and Rehabilitation has a subspecialty in Pain Medicine; 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 is a patient with a date of injury of 6/1/90. A utilization review determination dated 4/30/14 recommends non-certification of MRI thoracic and lumbar spine and LSO brace. 4/2/14 medical report identifies low back and mid-thoracic pain. She has undergone multiple low back surgeries. Thoracic pain radiates to the bilateral chest. Low back pain radiates down right lower leg along the bilateral L4 and right L5 distributions. On exam, no objective findings are noted, but the patient is said to have bilateral T7 and L4 radiculopathy and right L5 radicular pain. There is severe lumbago with ROM and pain along the incisional area. Recommendations include thoracic and lumbar ESIs, MRI, LSO brace, and pool therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of the Thoracic Spine:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back (Lumbar and Thoracic) Chapter, MRIs (magnetic resonance imaging)

**Decision rationale:** Regarding the request for thoracic MRI, CA MTUS does not address repeat MRIs. ODG states that repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). Within the documentation available for review, a medical report submitted after the utilization review report notes mid-thoracic pain that radiates to the bilateral chest. Thoracic radiculopathy does not typically manifest with objective findings and this complaint does appear to be progressive in nature as it was not documented previously. In light of the above issues, the currently requested thoracic MRI is medically necessary.

**MRI of the Lumbar Spine:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines-Low Back Chapter, MRI's

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back (Lumbar and Thoracic) Chapter, MRIs (magnetic resonance imaging)

**Decision rationale:** Regarding the request for lumbar MRI, CA MTUS does not address repeat MRIs. ODG states that repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). Within the documentation available for review, a medical report submitted after the utilization review report notes low back pain and a history of multiple low back surgeries. Low back pain radiates down right lower leg along the bilateral L4 and right L5 distributions. There is severe pain with ROM. Given the pending thoracic MRI along with ongoing low back pain in a clear dermatomal distribution and a history of multiple lumbar surgeries, the request for MRI appears reasonable. In light of the above, the currently requested lumbar MRI is medically necessary.

**LSO Brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

**Decision rationale:** Regarding the request for LSO brace, ACOEM guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Within the documentation available for review, the patient is well beyond the acute stage of relief and there is no documentation of a pending/recent spine surgery, spinal instability, compression fracture, or another clear rationale for a brace in the management of this patient's chronic injury. In the absence of such documentation, the currently requested LSO brace is not medically necessary.

