

Case Number:	CM14-0187689		
Date Assigned:	11/17/2014	Date of Injury:	04/15/2002
Decision Date:	01/06/2015	UR Denial Date:	10/29/2014
Priority:	Standard	Application Received:	11/11/2014

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 Family 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 44-year old nursing assistant reported an injury to her low back after assisting a 500-lb patient to stand on 4/15/12. Initial treatment included medications. An orthopedist recommended back surgery, but told her she should have gastric bypass surgery first. (She weighed approximately 300 lbs at the time.) In 2007, she underwent gastric bypass surgery, which was complicated by postoperative hemorrhage. An immediate second surgery was required, and she remained in the hospital for three weeks. She began to experience cramping in her stomach and legs after the surgery. In about 2011 she fell while stepping off a curb, and tore an Achilles' tendon. During the surgery to repair it she developed right elbow pain when an IV was placed in her arm. Both the ankle injury and the elbow pain/injury were ultimately deemed work-related. Current diagnoses include right medial epicondylitis, right cubital tunnel syndrome, right shoulder impingement syndrome, L3-S1 disc degeneration, degenerative scoliosis, left greater trochanter bursitis, and anxiety. Her current primary treater is an orthopedic spine specialist. She has also seen two secondary treaters. A psychologist evaluated her on 10/2/14 and diagnosed adjustment disorder with mixed anxiety and depressed mood. The psychologist made several pertinent observations, including that the patient converts her psychological problems into physical complaints, and that she uses somatic complaints to avoid thinking of or dealing with psychological problems. The psychologist also noted that the patient is very fearful of surgery given her experience with gastric bypass, and that the only way she would consent to further surgery would entail not being able to walk or having intolerable pain. A pain specialist has evaluated the patient as well. He recommended and performed bilateral multilevel medial branch blocks, followed by radiofrequency ablation on 6/16/14. Her primary treater has performed two steroid injections to her right hip and one to her right elbow. She also had cold laser therapy on her right elbow, and completed a course of physical therapy. All of

these treatments were reported to have produced significant pain reduction and improvement in function. However, the documentation reveals that the patient's pain levels according to a visual analogue scale have not changed significantly. She has been off work since a few weeks after her injury date, and has not returned to it. There has been no change in her multiple medications, which include long and short acting forms of oxycodone, as well as Baclofen and Xanax. A 10/20/14 note from the primary treater's office documents that the patient has daily cramping in her thighs and shins. Notable physical findings include tenderness of the left more than right greater trochanter, mild weakness of the right ankle and foot, marked weakness of left hip flexion, and decreased sensation in the left L5 and S1 distribution. The provider states that he has not been provided with the patient's previous lumbar MRI, and that he requires authorization of a lumbar MRI to evaluate the cause of her ongoing cramping sensations. He also states that she has ongoing severe left greater trochanter pain, which has improved temporarily with injections, and that her symptoms are consistent with bursitis, and that he plans to refer her to a specialist for consideration of left greater trochanter bursectomy. These requests were denied in UR on 10/29/14 on the basis that no red flags were present to indicate a need for MRI per ACOEM guidelines, and that steroid injections are the first-line treatment for trochanteric bursitis according to ODG.

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 without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 53, 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, Chronic Pain Treatment Guidelines Page(s): 10.

Decision rationale: The MTUS Chronic Pain Guidelines do not specifically address lumbar MRIs. However, per page 10 of the Guidelines, when a patient is diagnosed with chronic pain and the treatment for the condition is covered in the clinical topics sections but is not addressed in the chronic pain medical treatment guidelines, the clinical topics section applies to that treatment. According to clinical topics low back section, unequivocal objective findings that identify specific nerve root compromise on neurological exam are sufficient to warrant imaging in patients who do not respond to treatment and who would consider surgery as an option. When the neurological exam is less clear, further physiologic evidence of nerve root dysfunction should be obtained before ordering imaging. Indiscriminant imaging will result in false positive findings that are not the source of the patient's symptoms and do not warrant surgery. The clinical documentation in this case does not support the performance of a lumbar MRI. The patient has already had a lumbar MRI which apparently revealed multifocal disc degeneration and scoliosis. Not having easy access to the previous performed MRI is not really a reason for repeating it, especially since it is unclear how obtaining a second MRI would change the treatment plan. On 10/2/14, this patient stated that she would not consider surgery unless she was unable to walk nor had unbearable pain. Since this is not currently the case, this patient is not a surgical candidate and lumbar MRI is not indicated. In addition, this patient's neurological

findings are not unequivocal. She has pain and cramping in both legs, which is not consistent with any specific nerve root compromise. She has decreased sensation in the left L5 and S1 dermatomes, but weakness in both left and right lower extremities. Further studies should be performed to evaluate nerve root dysfunction prior to obtaining any MRI. Based on the MTUS citations above and on the clinical findings in this case, a lumbar MRI is not medically necessary.

Referral to [REDACTED]: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-344.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 43-44, 79-80. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: UptoDate, on online evidence-based review service for clinicians (www.uptodate.com), Nocturnal leg cramps; and Trochanteric bursitis

Decision rationale: According to the MTUS references cited above, determining whether a patient suffers from a pathologic condition may not always be straightforward. Workers may believe that they have a physical injury when the real problem is a lack of fit with their job duties. Such workers may present with the development of symptoms after a minor physiologic stress, and often may have multiple symptoms with non-specific physical findings. Performing multiple procedures and tests in this setting is described as an incomplete or inaccurate approach to patient assessment that may set the stage for the prolongation of medical care, delayed recovery and the development of a range of behaviors by the patient in order to prove that there is a real injury that precludes return to work. In cases of delayed recovery and prolonged time away from work, the clinician should determine whether specific obstacles are preventing the patient from returning to work. The clinician should judiciously select and refer to specialists who will support functional recovery as well as provide expert recommendations. The clinician should always think about differential diagnoses. This should involve stepping back and reevaluating the patient and the entire clinical picture. Symptoms or physical findings that have developed since the injury may not be consistent with the original diagnosis. A detailed history and physical exam should be conducted. Appropriate studies may be performed. The first step in managing delayed recover is to document the patient's current state of functional ability. Goals for functional recovery can then be framed with reference to this baseline. After evaluation of the evidence-based references above and the clinical documentation made available for my review, I have concluded that referral to a specialist for consideration for left greater trochanter bursectomy is not medically necessary.