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| Case Number: | CM15-0000388 | | |
| Date Assigned: | 01/09/2015 | Date of Injury: | 02/09/2012 |
| Decision Date: | 03/10/2015 | UR Denial Date: | 12/04/2014 |
| Priority: | Standard | Application Received: | 01/02/2015 |

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Florida

Certification(s)/Specialty: Neurology, Pain Management

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 56 year old female with a work injury date of 02/09/2012. She states the injury occurred when she lifted up a child at a work event. She noted immediate onset of tingling and some pins/needles type sensation in all extremities as well as pain which went into her left hip and buttock. Prior treatments include chiropractic treatments, analgesic and anti-inflammatory medications and physical therapy. Diagnoses included severe cervical spondylosis and anterior hypertrophic spurring from cervical 5 - thoracic 1, non-verifiable cervical radiculitis, thoracolumbar spondylosis and multilevel facet arthropathy with degenerative disc disease and anterior spurring, non-verifiable lumbar radiculitis with a history of scoliosis. Treatment to date has included lumbar MRI done on 11/28/2012 showing multilevel degenerative disc disease and MRI of thoracic spine done on 09/28/2012 showing levoscoliosis and small disc protrusion. MRI of the cervical spine also done on 09/08/2012 showed spinal stenosis, foraminal narrowing, annular bulging and degenerative changes. Most recent MRI revealed multiple level degenerative changes with disc degeneration and bulging at virtually all levels of the lumbar spine. There was also facet degeneration at multiple levels of the lumbar spine. There was foraminal stenosis at multiple levels, more so on the right side at the lumbar 4 - lumbar 5 and lumbar 5 - sacral 1 level. On 11/06/2014 the injured worker (IW) presented for follow up with low back pain radiating into the left hip. She was also complaining of intermittent paresthesias and pain down both legs. Physical exam noted tenderness to palpation over the lower lumbosacral spine and into adjacent paraspinous regions bilaterally. Straight leg raising test was negative bilaterally. The provider requested MRI of the lumbar spine and lumbar epidural steroid

injection. On 12/04/2014 utilization review non-certified the MRI noting there were no red flags for serious pathology and there was no indication of a new or progressive neurologic deficit. Epidural steroid injection was also non-certified noting there was inadequate evidence of radiculopathy. Guidelines cited were CA MTUS and ACOEM. On 01/02/2015 the injured worker submitted an application to IMR for review of the request for MRI of the lumbar spine and lumbar epidural steroid injection.

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 Page(s): 304.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Indications for imaging -- Magnetic resonance imaging: - Thoracic spine trauma: with neurological deficit - Lumbar spine trauma: trauma, neurological deficit - Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit) - Uncomplicated low back pain, suspicion of cancer, infection, other "red flags" - Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. - Uncomplicated low back pain, prior lumbar surgery - Uncomplicated low back pain, cauda equina syndrome - Myelopathy (neurological deficit related to the spinal cord), traumatic - Myelopathy, painful - Myelopathy, sudden onset - Myelopathy, stepwise progressive - Myelopathy, slowly progressive - Myelopathy, infectious disease patient - Myelopathy, oncology patient

Decision rationale: On 11/06/2014 the injured worker (IW) presented for follow up with low back pain radiating into the left hip. She was also complaining of intermittent paresthesias and pain down both legs. Physical exam noted tenderness to palpation over the lower lumbosacral spine and into adjacent paraspinal regions bilaterally. Straight leg raising test was negative bilaterally. The medical records do not report neurologic deficits in the lower extremity of weakness or sensory loss. ODG supports MRI for low back pain with progressive neurologic deficit. As such the medical records do not support medical necessity of MRI lumbar spine in the insured.

LESI (lumbar epidural steroid injection): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. (1) Radiculopathy (due to herniated

nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. (2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). (3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.

Decision rationale: On 11/06/2014 the injured worker (IW) presented for follow up with low back pain radiating into the left hip. She was also complaining of intermittent paresthesias and pain down both legs. Physical exam noted tenderness to palpation over the lower lumbosacral spine and into adjacent paraspinal regions bilaterally. Straight leg raising test was negative bilaterally. The medical records do not report neurologic deficits in the lower extremity of weakness or sensory loss. The medical records provided for review do not document physical exam findings consistent with radiculopathy in association with plan for epidural steroid injection or document objective functional gain or pain improvement in terms of duration or degree in relation to first ESI performed in support of second ESI. ODG guidelines support ESI when (1) Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. (2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). (3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance. As such the medical records do not support the use of ESI congruent with ODG guidelines.