

Case Number:	CM15-0101307		
Date Assigned:	06/03/2015	Date of Injury:	12/16/1996
Decision Date:	09/25/2015	UR Denial Date:	05/11/2015
Priority:	Standard	Application Received:	05/27/2015

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: California, Indiana, New York
Certification(s)/Specialty: Internal Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 73 year old male who sustained an industrial injury on 12-16-96. He had complaints of low back pain. He had lumbar surgery and two corrective surgeries. Progress report dated 2-19-15 reports increasing, constant, aching, and nagging mid back pain. The pain becomes unbearable when he tries to walk. The pain radiates to the left thigh and stops at the knee. He has complaints of pain in the left "ball of foot" aggravated by walking. Medications help to relieve the pain. Diagnoses include: essential tremor, status post L5-S1 posterior instrumented fusion, lumbar dextroscoliosis, left L2-3 lateral recess stenosis with L3 radiculitis, L4-5 stenosis with claudication, left L5-S1 foraminal stenosis. Plan of care includes: refer to neurology regarding tremor, recommend upright MRI of the lumbar spine. Follow up when the study is complete.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-5. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, MRI lumbar spine.

Decision rationale: Pursuant to the Official Disability Guidelines, MRI of the lumbar spine is not medically necessary. MRIs of the test of choice in patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy, it is not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and findings suggestive of significant pathology. Indications (enumerated in the official disability guidelines) for imaging include, but are not limited to, lumbar spine trauma, neurologic deficit; uncomplicated low back pain with red flag; uncomplicated low back pain prior lumbar surgery; etc. ACOEM states unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients not respond to treatment and who would consider surgery an option. See the ODG for details. In this case, the injured worker's working diagnoses are essential tremor; status post L5-S1 posterior instrumented fusion; lumbar dextroscoliosis; left L2-L3 lateral recess stenosis with L3 radiculitis; L4-L5 stenosis with claudication; L5-S1 foraminal stenosis; and peripheral vascular disease, GERD, obesity, elevated cholesterol and erectile dysfunction. Date of injury is December 16, 1996. The request for authorization is May 17, 2015. According to a February 19, 2015 neurosurgical progress note, subjectively the injured worker has back pain. The injured worker has a history of lumbar surgery with two subsequent corrective surgeries. The injured worker has persistent pain. Injured worker has a history of essential tremor. Objectively, straight leg raising in the sitting position is negative for particular pain. There is no palpable tenderness over the dorsal spine. There is no tenderness over the iliac crest. The treating provider wants a referral to urology for the "tremors". The treating provider is requesting an upright MRI. The injured worker underwent MRI lumbar spine December 17, 2014. There are no unequivocal objective findings that identify a specific nerve compromise on neurologic examination. Straight leg raising is negative. There was no tenderness over the lumbar or thoracic spine. There is no clinical rationale for the upright MRI in the guidelines (ACOEM) does not support the use of this imaging study. Based on clinical information medical record, peer-reviewed evidence-based guidelines, no documentation with clinical findings to support a repeat MRI (upright) lumbar spine, and guideline non-recommendations, MRI of the lumbar spine is not medically necessary.

One (1) neurology consult: Overtured

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines Chapter 7, Independent Medical Examinations and Consultations, page 127.

Decision rationale: Pursuant to the ACOEM, one (1) neurology consultation is medically necessary. An occupational health practitioner may refer to other specialists if the diagnosis is certain or extremely complex, when psychosocial factors are present, or when the plan or course

of care may benefit from additional expertise. A consultation is designed to aid in the diagnosis, prognosis and therapeutic management of a patient. The need for a clinical office visit with a healthcare provider is individualized based upon a review of patient concerns, signs and symptoms, clinical stability and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medications such as opiates for certain antibiotics require close monitoring. In this case, the injured worker's working diagnoses are essential tremor; status post L5 - S1 posterior instrumented fusion; lumbar dextro-scoliosis; left L2 - L3 lateral recess stenosis with L3 radiculitis; L4 - L5 stenosis with claudication; L5 - S1 foraminal stenosis; and peripheral vascular disease, GERD, obesity, elevated cholesterol and erectile dysfunction. Date of injury is December 16, 1996. The request for authorization is May 17, 2015. According to a February 19, 2015 neurosurgical progress note, subjectively the injured worker has back pain. The injured worker has a history of lumbar surgery with two subsequent corrective surgeries. The injured worker has persistent pain. Injured worker has a history of essential tremor. Objectively, straight leg raising in the sitting position is negative for particular pain. There is no palpable tenderness over the dorsal spine. There is no tenderness over the iliac crest. The treating provider wants a referral to neurologist for the "tremors". The treating provider is requesting an upright MRI. The injured worker underwent MRI lumbar spine December 17, 2014. There are no unequivocal objective findings that identify a specific nerve compromise on neurologic examination. Straight leg raising is negative. There was no tenderness over the lumbar or thoracic spine. A consultation is designed to aid in the diagnosis, prognosis and therapeutic management of a patient. The treating provider is referring the injured worker to a neurologist for evaluation of the "tremors". The request for a neurology consultation was certified. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines and a referral for "tremors" to a neurologist, one (1) neurology consultation is medically necessary.