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| Case Number: | CM15-0108895 | | |
| Date Assigned: | 06/15/2015 | Date of Injury: | 06/23/2006 |
| Decision Date: | 07/14/2015 | UR Denial Date: | 05/15/2015 |
| Priority: | Standard | Application Received: | 06/05/2015 |

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 43 year old female who sustained an industrial injury on 06/23/2006. Treatment provided to date has included: lumbar injections (4), medications, and conservative therapies/care. Diagnostic testing was not provided nor discussed. There were no noted previous injuries or dates of injury, and no noted comorbidities. On 05/11/2015, physician progress report noted that the injured worker reported going to the urgent care because she thought she had injured her hip secondary to a fall. The injured worker stated that her leg gave out and she felt a pop in her hip while she was stepping down off a curb; however, it was also noted that the injured worker did not actually fall. The progress report, as well as other reports, were hand written and difficult to decipher. The report did not appear to indicate any specific complaints of pain and there was no pain severity rating noted. The physical exam revealed decreased sensation to pinprick in the left thigh, and tenderness and tightness in the left lower back and buttocks. The range of motion drawing was difficult to decipher but it did appear to show some limited range of motion. An operative note dated 03/25/2015, showed diagnoses of lumbar degenerative disc protrusions at L4-5 and L5-S1, lumbago, and lumbosacral radiculitis. Plan of care includes a MRI of the lumbar spine, lumbar epidural steroid injection, medications, and follow-up. A previous progress report dated 04/24/2015, stated that the injured worker was seen for follow-up after receiving a lumbar injection on 03/25/2015 which was reported to no help as much. The injured worker's work status was not specified. Requested treatments include MRI of the lumbar spine.

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): 700-07. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back (updated 04/29/15).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Special Studies and Diagnostic and Treatment Considerations Page(s): 303.

Decision rationale: Regarding the indications for imaging in case of back pain, MTUS guidelines stated: "Lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. However, it may be appropriate when the physician believes it would aid in patient management. Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures)." Furthermore, and according to MTUS guidelines, MRI is the test of choice for patients with prior back surgery, fracture or tumors that may require surgery. In this case, there is no documentation that conservative care has been exhausted to address the numbness in the left lower extremity. The patient does not have any clear evidence of new lumbar nerve root compromise. There is no clear evidence of significant change in the patient signs or symptoms suggestive of new pathology. Therefore, the request for lumbar MRI is not medically necessary.