

Case Number:	CM15-0109845		
Date Assigned:	06/16/2015	Date of Injury:	01/30/2014
Decision Date:	07/15/2015	UR Denial Date:	06/01/2015
Priority:	Standard	Application Received:	06/08/2015

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: North Carolina

Certification(s)/Specialty: Family Practice

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 61-year-old female, who sustained an industrial injury on 01/30/2014. She reported injury to her low back. Treatment to date has included medications, trigger point injection, lumbar epidural injection and physical therapy. According to a progress report dated 03/05/2015, the injured worker presented with back pain. Radiation of pain to the right lower extremity and right buttock and posterior thigh was noted. She denied bowel or bladder dysfunction. Physical examination demonstrated 5/5 strength in the bilateral lower extremities L2-S1. 2+ patellar tendon reflexes were noted. There was no ankle clonus. Straight leg raise was negative. MRI of the lumbar spine on 03/17/2014 was of limited quality. Radiographs of the lumbar spine performed on 08/27/2014 were noted to be of relatively poor quality. MRI of the lumbar spine on 02/06/2015 was noted to be of poor quality low field strength open MRI. There was suggestion of at least moderate central canal stenosis at L4-5; there was no fine detail. Impression included lumbar disc herniation. The provider noted that the injured worker was localizing her pain exactly to the L4-5 level and was worse with bending and could radiate down the right leg. MRI suggested spinal stenosis. Radiology reports suggested a mobile spondylolisthesis at this level. She had not tolerated oral medication, and physical therapy only made symptoms worse. She had only one week of improvement after the L4-5 epidural steroid injection. She was considered to be a surgical candidate and wanted to proceed with surgery. The treatment plan included chiropractic care, an injection and a third MRI. She was to follow-up after imaging with her decision about surgery. On 04/16/2015, the injured worker underwent right L4 and right L5 transforaminal epidural steroid injection. According to a progress report

dated 04/24/2015, the injured worker had not noticed any relief yet with the epidural injection. She did report getting good relief with the sacroiliac joint injection and piriformis trigger point injection. She wished to repeat that prior to considering surgical options. An authorization request dated 05/21/2015 was submitted for review for a consultation for the low back and an MRI of the lumbar spine. Currently under review is the request for referral to orthopedic surgeon for consultation of low back and 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:

Referral to orthopedic surgeon for consultation of low back: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Occupational Medicine Practice Guidelines, 2nd Edition, 2004 page 127, Health practitioner.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 3 Initial Approaches to Treatment.

Decision rationale: Per the ACOEM :The health practitioner may refer to other specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for 1. Consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability. The patient has ongoing complaints of ongoing pain that have failed treatment by the primary treating physician. Therefore, criteria for an orthopedic management consult have been met and the request is medically necessary.

MRI of the lumbar spine: 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): 303-304.

Decision rationale: The ACOEM chapter on low back complaints and special diagnostic studies states: 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, computed tomography [CT] for bony structures). Relying solely on imaging studies to evaluate the source of low back and related

symptoms carries a significant risk of diagnostic confusion (false positive test results) because of the possibility of identifying a finding that was present before symptoms began and therefore has no temporal association with the symptoms. Techniques vary in their abilities to define abnormalities (Table 12-7). Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Because the overall false-positive rate is 30% for imaging studies in patients over age 30 who do not have symptoms, the risk of diagnostic confusion is great. There is no recorded presence of emerging red flags on the physical exam. There is evidence of nerve compromise on physical exam but there is not mention of consideration for surgery or complete failure of conservative therapy. For these reasons, criteria for imaging as defined above per the ACOEM have not been met. Therefore, the request is not medically necessary.