MAXIMUS Federal Services

Case Number:	CM15-0148111		
Date Assigned:	08/11/2015	Date of Injury:	09/29/1994
Decision Date:	09/08/2015	UR Denial Date:	07/01/2015
Priority:	Standard	Application Received:	07/30/2015

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: Texas, Florida, California
Certification(s)/Specialty: Preventive Medicine, Occupational 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 70 year old female who sustained an industrial injury on 9-29-94 in a fall injuring her neck and low back. She was medically evaluated by numerous providers and in 1999 had back surgery. She currently complains of neck pain; constant, burning, sharp low back pain with radiation down both legs and with numbness and tingling. Her pain level was 9 out of 10. On physical exam of the cervical spine there was tenderness of facet joints, decreased range of motion; lumbar spine revealed tenderness of facet joints, decreased range of motion; left and right sacroiliac joint tenderness. Medications were tizanidine, gabapentin, Norco. Diagnoses include lumbago; cervical spondylosis; lumbar degenerative disc disease; lumbar radiculopathy; sacroiliac joint dysfunction; cervicalgia; headache; cervical disc disorder; colon cancer. Treatments to date include medications; physical therapy with relief; home exercise program; cervical epidural injections with 80% relief. Diagnostics include MR lumbar spine (6-8-14) showing extensive prior surgery, facet degenerative changes, minimal disc protrusion, mild neural foraminal encroachment, degenerative changes of the facet joints. In the progress note dated 6-25-15 the treating provider's plan of care includes a request for 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, QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back-Lumbar & Thoracic (Acute & Chronic), MRI's.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): American College of Occupational and Environmental Medicine Page 303, Low Back Complaints. Decision based on Non-MTUS Citation ODG, Low back, MRI.

Decision rationale: This claimant was injured in 1994 and had back surgery. There is still neck and back pain. Diagnoses included lumbago; cervical spondylosis; lumbar degenerative disc disease; lumbar radiculopathy; sacroiliac joint dysfunction; cervicalgia; headache; cervical disc disorder; and colon cancer. The MR of the lumbar spine from June 2014 showed extensive prior surgery, facet degenerative changes, minimal disc protrusion, mild neural foraminal encroachment, and degenerative changes of the facet joints. The reason for the repeat MRI is not documented. There are no documented changes in neurologic signs. Under MTUS/ACOEM, although there is subjective information presented in regarding increasing pain, there are little accompanying physical signs. Even if the signs are of an equivocal nature, the MTUS note that electrodiagnostic confirmation generally comes first. They note "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." The guides warn that indiscriminate imaging will result in false positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. I did not find electrodiagnostic studies. It can be said that ACOEM is intended for more acute injuries; therefore other evidence-based guides were also examined. The ODG guidelines note, in the Low Back Procedures section: 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; Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. (For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383) (Andersson, 2000) Uncomplicated low back pain, prior lumbar surgery; Uncomplicated low back pain, cauda equina syndrome. These criteria are also not met in this case; the request was appropriately not medically necessary under the MTUS and other evidence-based criteria.