

Case Number:	CM15-0182463		
Date Assigned:	09/23/2015	Date of Injury:	09/30/2010
Decision Date:	10/28/2015	UR Denial Date:	09/01/2015
Priority:	Standard	Application Received:	09/16/2015

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 60-year-old female, who sustained an industrial injury on 9-30-2010. The injured worker is undergoing treatment for lumbar spondylosis, lumbar radiculopathy status post fusion, and cervical spondylosis. Dates of service reviewed included: 11-9-2011 to 8-10-15. On 5-12-15, she reported chronic low back and right leg pain, which she indicated as being improved since her surgery. She also reported constant neck pain with bilateral shoulder pain. Physical examination revealed healed surgery scars on the neck and low back and a diminished range of motion of the neck and low back. On 7-14-15, she reported low back, bilateral posterior thigh and lateral thigh pain. She indicated the pain was different than it was before surgery. She also reported neck and scapular pain with associated arm numbness. There is notation of a cervical epidural injection being approved. Physical examination revealed pain when going from sitting to standing, tenderness in the lumbosacral and cervical-thoracic areas, along with a decreased range of motion of the neck and low back. Her pain level and a description of pain are not documented. The treatment and diagnostic testing to date has included: cervical spine x-rays (noted as taken approximately February 2015) are reported to reveal cervical fusion and moderate to severe disc degeneration; and lumbar spine x-rays reported as revealing good anterior graft placement and posterior instrumentation. Lumbar and cervical fusions are noted as being completed (date is reported as approximately 2 years earlier in 2013), x-rays of the lumbar spine (7-10-2015), physical therapy. Medications have included: Soma, Norco and Flexeril. Current work status: is not documented. The request for authorization is for: x-ray of the lumbar spine (5 views), magnetic resonance imaging of the lumbar spine with and without contrast, and

x-ray of the cervical spine (4 views). The UR dated 9-1-2015: non-certified the request for x-ray of the lumbar spine (5 views), magnetic resonance imaging of the lumbar spine with and without contrast, and x-ray of the cervical spine (4 views).

IMR ISSUES, DECISIONS AND RATIONALES

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

X-rays, Lumbar spine, 5 views: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back, Lumbar & Thoracic - Radiography (x-rays).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) The California MTUS-ACOEM guides, specifically Chapter 12 for the back, note on page 303: Key case observations are as follows. The claimant was injured in 2010 with lumbar spondylosis, lumbar radiculopathy status post fusion, and cervical spondylosis. As of July, there was low back, bilateral posterior thigh and lateral thigh pain. She indicated the pain was different than it was before surgery. She also reported neck and scapular pain with associated arm numbness. Cervical spine x-rays from February 2015 show cervical fusion and moderate to severe disc degeneration; and lumbar spine x-rays show good anterior graft placement and posterior instrumentation. Lumbar and cervical fusions were noted as being completed (date is reported as approximately 2 years earlier in 2013). The MTUS notes that the criteria for ordering imaging studies are: emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery and clarification of the anatomy prior to an invasive procedure. The patient does not meet these criteria. Further, unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. In this case, there is no documentation of equivocal neurologic signs. Further, imaging studies to this area had already been accomplished, and the reason for repeating the study is not clinically clear. The request was appropriately not medically necessary.

MRI (magnetic resonance imaging), Lumbar spine with and without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back, Lumbar & Thoracic - Magnetic resonance imaging (MRI).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: As noted, key case observations are as follows. The claimant was injured in 2010 with lumbar spondylosis, lumbar radiculopathy status post fusion, and cervical spondylosis. As of July, there was low back, bilateral posterior thigh and lateral thigh pain. She indicated the pain was different than it was before surgery. She also reported neck and scapular pain with associated arm numbness. Cervical spine x-rays from February 2015 show cervical fusion and moderate to severe disc degeneration; and lumbar spine x-rays show good anterior graft placement and posterior instrumentation. Lumbar and cervical fusions were noted as being completed (date is reported as approximately 2 years earlier in 2013). 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 injuries that are more acute; 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.

X-rays, Cervical spine, 4 views: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines: Neck & Upper Back - Radiography.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

Decision rationale: As shared previously, key case observations are as follows. The claimant was injured in 2010 with lumbar spondylosis, lumbar radiculopathy status post fusion, and cervical spondylosis. As of July, there was low back, bilateral posterior thigh and lateral thigh pain. She indicated the pain was different than it was before surgery. She also reported neck and scapular pain with associated arm numbness. Cervical spine x-rays from February 2015 show cervical fusion and moderate to severe disc degeneration; and lumbar spine x-rays show good anterior graft placement and posterior instrumentation. Lumbar and cervical fusions were noted as being completed (date is reported as approximately 2 years earlier in 2013). The California

MTUS-ACOEM guides, specifically Chapter 8 for the neck, note on page 177: For most patients presenting with true neck or upper back problems, special studies are not needed unless a three or four week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red flag conditions are ruled out. Criteria for ordering imaging studies are: Emergence of a red flag, Physiologic evidence of tissue insult or neurologic dysfunction, Failure to progress in a strengthening program intended to avoid surgery, Clarification of the anatomy prior to an invasive procedure Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. In this case, the physiologic evidence of dysfunction is not clear. The testing was appropriately not medically necessary.