

Case Number:	CM15-0182614		
Date Assigned:	09/23/2015	Date of Injury:	01/16/2014
Decision Date:	11/06/2015	UR Denial Date:	08/21/2015
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, California
 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:

This is a 51-year-old female patient who sustained an industrial injury on January 16, 2014. Diagnoses have included chronic back pain, lumbar radiculopathy, and lumbar disc degeneration. Per the doctor's note dated 8/14/2015, she had complaints of low back pain with radiation to the left lower extremity with tingling and numbness in the left foot. The physical examination revealed lumbar spine-tenderness, decreased range of motion and abnormal straight leg raising test on the left. Per the doctor's note dated 8/7/2015, she had complaints of severe low back pain rated as 10 out of 10, with radiation to the left lower extremity with tingling and numbness in the left foot. The physical examination revealed lumbar spine-tenderness, decreased range of motion and abnormal straight leg raising test on the left. The medications list includes naproxen and nortriptyline. She has had an MRI lumbar spine dated 3-20-2014, which revealed multiple level disc bulges, spondylosis, desiccated disc at L5-S1, and narrowing of the neural foramina bilaterally at L1-3. Per the doctor's note dated 7/2/2014, she is status post lumbar ESI on 6/26/2014. She had pain at 7/10 with no significant improvement after lumbar ESI. She has had epidural steroid injection on 10-6-2014. Per the note dated 10/31/2014, she had low back pain at 7/10. Per the note dated 5/1/2014, she had 3 lumbar ESIs in 2010. She has had 12 sessions of physical therapy with "no benefit"; 5 sessions of acupuncture "without significant functional improvement"; home exercise and a TENS unit for this injury. She has been working light duty. The treating physician's plan of care includes MRI of the lumbar spine and lumbar epidural steroid injections for L4-S1, which were both denied on 8-21-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Lumbar Spine: Overturned

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Low Back (updated 09/22/15) MRIs (magnetic resonance imaging).

Decision rationale: Request: MRI Lumbar Spine. Per the ACOEM low back guidelines, "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)." Per the records provided patient has had an MRI lumbar spine dated 3-20-2014, which revealed multiple level disc bulges, spondylosis, desiccated disc at L5-S1, and narrowing of the neural foraminal bilaterally at L1-3. Per the cited guidelines "Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation)." Per the note dated 8/7/15, the patient has significant changes in signs/symptoms- severe low back pain rated as 10 out of 10, with radiation to the left lower extremity with tingling and numbness in the left foot. The patient has significant objective findings on the physical examination-lumbar spine-tenderness, decreased range of motion and abnormal straight leg raising test on the left. It is medically appropriate to perform lumbar spine MRI to evaluate patient's worsening symptoms and to rule out red flags. The request of MRI lumbar spine is medically necessary and appropriate for this patient at this juncture.

Lumbar ESI L4-S1 x1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: Request: Lumbar ESI L4-S1 x1. The MTUS Chronic Pain Guidelines regarding Epidural Steroid Injections state, "The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-

term functional benefit. Epidural steroid injection can offer short-term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program." Per the cited guideline, criteria for ESI are "1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year." Unequivocal evidence of radiculopathy documented by physical examination and corroborated by electro diagnostic testing is not specified in the records provided. As stated above, epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. Per the doctor's note dated 7/2/2014, she is status post lumbar ESI on 6/26/2014. She had pain at 7/10 with no significant improvement after lumbar ESI. She has had an epidural steroid injection on 10-6-2014. Per the note dated 10/31/2014, she had low back pain at 7/10. Documented evidence of functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks with previous lumbar epidural steroid injections is not specified in the records provided. As stated above, ESI alone offers no significant long-term functional benefit. Lumbar ESI L4-S1 x1 is not medically necessary for this patient.