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| <b>Case Number:</b>   | CM15-0190754 |                              |            |
| <b>Date Assigned:</b> | 10/02/2015   | <b>Date of Injury:</b>       | 01/25/1999 |
| <b>Decision Date:</b> | 11/18/2015   | <b>UR Denial Date:</b>       | 09/11/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 09/28/2015 |

### 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: California, District of Columbia, Maryland  
 Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 50 year old male, who sustained an industrial injury on 1-25-99. The injured worker is being treated for lumbar disc with radiculitis, low back pain and myofascial pain. Treatment to date has included lumbar spine fusion surgery, physical therapy, functional restoration program, transcutaneous electrical nerve stimulation (TENS) unit, trigger point injection, oral medications including Ibuprofen 800mg, Desyrel 100mg, Zanaflex 4mg, Lidoderm 5%, Lyrica 75mg and Imitrex 50mg. On 7-1-15 and on 8-31-15, the injured worker complains of continued low back pain which worsens as the day progresses with radiation to bilateral lower extremities. He is currently not working. Physical exam performed on 7-1-15 revealed no abnormalities and on 8-31-15 revealed non-antalgic gait, mildly restricted range of motion of lumbar spine, well healed surgical lumbar scar, tenderness to palpation over the left sacroiliac area, guarding at left L3-5 and diminished L4 dermatome to temperature. The treatment plan included request for X-ray of lumbar spine and continuation of home exercise program. On 9-11-15 request for X-ray of lumbar spine was non-certified by utilization review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**X-Ray for the Lumbar Spine:** Overturned

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Radiography (x-rays).

**Decision rationale:** Per the ODG guidelines regarding x-rays: Not recommend routine x-rays in the absence of red flags. (See indications list below.) Lumbar spine radiography 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 6 weeks. However, some providers feel it "may" be appropriate when the physician believes it would aid in patient expectations and management. The theory is that this reassurance may lessen fear avoidance regarding return to normal activities and exercise, but this has not been proven. (Ash, 2008) Indiscriminant imaging may result in false positive findings that are not the source of painful symptoms and do not warrant surgery. A history that includes the key features of serious causes will detect all patients requiring imaging. (Kendrick, 2001) (Bigos, 1999) (Seidenwurm, 2000) (Gilbert, 2004) (Gilbert2, 2004) (Yelland, 2004) (Airaksinen, 2006) (Chou, 2007) According to the American College of Radiology, "It is now clear from previous studies that uncomplicated acute low back pain is a benign, self-limited condition that does not warrant any imaging studies." (ACR, 2000) A Recent quality study concludes that MRI is no better than x-rays in management of low back pain, if the cost benefit analysis includes all the treatment that continues after the more sensitive MRI reveals the usual insignificant disc bulges and herniations. Indications for imaging, Plain X-rays: Thoracic spine trauma: severe trauma, pain, no neurological deficit; Thoracic spine trauma: with neurological deficit; Lumbar spine trauma (a serious bodily injury): pain, tenderness; Lumbar spine trauma: trauma, neurological deficit; Lumbar spine trauma: seat belt (chance) fracture; Uncomplicated low back pain, trauma, steroids, osteoporosis, over 70; Uncomplicated low back pain, suspicion of cancer, infection; Myelopathy (neurological deficit related to the spinal cord), traumatic; Myelopathy, painful; Myelopathy, sudden onset; Myelopathy, infectious disease patient; Myelopathy, oncology patient; Post-surgery: evaluate status of fusion. Per progress report dated 7/1/15, it was noted that the injured worker continues to have low back pain which worsens as the day progresses. His pain radiates bilaterally down the lower extremities left greater than right. He reported worsening pain axial and radicular, bilaterally. I respectfully disagree with the UR physician's assertion that there is no indication for x-ray. The injured worker continues to have worsening radicular pain. Additionally, the injured worker is post surgery. X-ray is also indicated to evaluate the status of fusion. The request is medically necessary.