

Case Number:	CM15-0191858		
Date Assigned:	10/05/2015	Date of Injury:	08/01/2007
Decision Date:	11/12/2015	UR Denial Date:	09/21/2015
Priority:	Standard	Application Received:	09/29/2015

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 male individual who sustained an industrial injury on 8-1-07. The medical records indicate that the injured worker is being treated for bilateral low back pain with sciatic presence; bilateral lumbar radiculopathy; depression; lumbar intervertebral disc displacement without myelopathy; myalgia and myositis. He currently (9-11-15) complains of primarily right sided low back pain radiating into bilateral lower extremities with intermittent leg numbness and a few days ago his right leg went completely numb. On physical exam there was pain in the L4-5 and L5-S1 distribution, he ambulates with a normal gait, negative clonus, and negative straight leg raise. His pain level (7-6-15) was 5-9 out of 10 and on this date the physical exam noted myofascial trigger points into the right lumbar paraspinals and proximal gluteal muscles, decreased range of motion. Diagnostics to date included MRI of the lumbar spine (10-4-12) showing multilevel degenerative changes at L3-4 and L4-5, disc protrusion at L3-4, annular fissure at L4-5, and neural foraminal stenosis at L4-5. He has been treated with chiropractic treatments; acupuncture; epidural steroid injections with 50% relief for 3-4 years; physical therapy with no benefit; medications: high doses of ibuprofen with benefit. In the 9-11-15 progress note the treating provider's plan of care included requests for updated MRI of the lumbar spine; flexion, extension x-rays of the lumbar spine to evaluate for stability. The request for authorization was not present. On 9-21-15 Utilization Review non-certified the requests for MRI of the lumbar spine; x-ray of the lumbar spine 4 views.

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 without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.
Decision based on Non-MTUS Citation ODG Low Back Chapter.

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

Decision rationale: American College of Occupational and Environmental Medicine Page 303, Low Back Complaints 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 non-certified under the MTUS and other evidence-based criteria.

X-Ray of the Lumbar Spine 4+V: Upheld

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

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

Decision rationale: 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 non-certified.