

Case Number:	CM15-0200829		
Date Assigned:	10/15/2015	Date of Injury:	05/13/2009
Decision Date:	11/24/2015	UR Denial Date:	09/10/2015
Priority:	Standard	Application Received:	10/13/2015

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: Montana, Oregon, Idaho
 Certification(s)/Specialty: Orthopedic Surgery

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 55 year old female, who sustained an industrial injury on May 13, 2009. The initial symptoms reported by the injured worker are unknown. The injured worker was currently diagnosed as having lumbosacral spondylosis without myelopathy, sacroiliac joint pain, myofascial pain syndrome, muscle spasm, cervical degenerative disc disease and cervical spondylosis. Treatment to date has included injections, diagnostic studies, surgery and medication. The injured worker underwent bilateral sacroiliac joint injections on August 18, 2015. She noted a 50%-60% improvement in her low back pain. On September 2, 2015, the injured worker complained of lower back pain rated, on average, as a 7 on a 1-10 pain scale. She reported increased radicular pain in her right lower extremity. Her pain was constant with intermittent flare-ups. The pain was described as aching, hot-burning, shooting and throbbing. Her function was noted to improve 75% with medication. Physical examination of the lumbar spine revealed tenderness and spasm. Range of motions of the lumbar spine was noted to be restricted. Straight leg raising test was positive on the right at 60 degrees. The injured worker used a cane for assistance and her gait was antalgic. Notes stated that the injured worker underwent a fusion that was believed to be at the L3-S1 levels. The treating physician noted not having any possession of radiology reports. The injured worker believed that there were no x-rays performed after her surgery, which was about two years back from the date of exam. A request was made for x-rays of the lumbar spine flexion extension views to ensure that the fusion is solid. The treatment plan also included right L5-S1 and S1 transforaminal epidural steroid injection, medications and a follow-up visit. On September 9, 2015, utilization review denied a request for lumbar spine x-ray.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar spine x-ray: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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.

Decision rationale: The CA/MTUS ACOEM guidelines are silent on the issue of lumbar spine radiography. The ODG, low back section, does 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 re-assurance may lessen fear avoidance regarding return to normal activities and exercise, but this has not been proven. 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. 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. The documentation support that the injured worker has undergone a lumbar fusion. It was unclear from previous records whether she had ever had imaging to evaluate the fusion post-operatively. The guidelines do support radiography to evaluate the status of a fusion post-operatively. In addition, obtaining lumbar spine x-rays prior to performing lumbar epidural steroid injections is prudent in someone who has a lumbar fusion. Therefore the guidelines support the request and the request is medically necessary.