

Case Number:	CM15-0212922		
Date Assigned:	11/02/2015	Date of Injury:	07/02/2004
Decision Date:	12/14/2015	UR Denial Date:	10/23/2015
Priority:	Standard	Application Received:	10/29/2015

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:

This is a 60 year old male with a date of injury of July 2, 2004. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar post laminectomy syndrome, lumbar radiculopathy, and chronic pain syndrome. Medical records dated August 10, 2015 indicate that the injured worker complained of pain in the lumbar spine radiating down both lower extremities with numbness and tingling to both legs and feet, and pain rated at a level of 9 out of 10 and 4 to 5 out of 10 with medications. Per the treating physician (October 13, 2015), the employee was not working. The physical exam dated August 10, 2015 reveals decreased lumbar lordosis, tenderness to palpation over the bilateral erector spinae, latissimus dorsi, and quadratus lumborum, tenderness to palpation over the bilateral L4 and L5 spinous processes, decreased range of motion of the lumbar spine, positive straight leg raise bilaterally, and atrophy of the left thigh. The handwritten progress note dated October 13, 2015 documented a physical examination that showed tenderness and decreased range of motion of the lumbar spine and thoracic spine. Portions of the progress note were difficult to decipher. Treatment has included medications (Anaprox, Flexeril, Norco, Gabapentin, and Omeprazole). Magnetic resonance imaging of the lumbar spine (November 26, 2014) showed features of at least mild arachnoiditis in the caudal lumbar cistern at L4 through its termination with irregular distribution of nerve roots which appear adherent to one another, moderate chronic wedging of the T12 vertebral body with 60% reduction of vertical height anteriorly and 20% posteriorly, mild left and mild to moderate right lateral recess stenosis at T12-L1, moderate left and right lateral recess stenosis at L1-2, and mild bilateral stenosis of the lateral recesses at L2-3. The utilization review

(October 23, 2015) non-certified a request for a lumbar brace, updated magnetic resonance imaging of the lumbar spine, and continuation of medication and treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: The California MTUS, specifically Chapter 12 of ACOEM dealing with the low back, note on page 298: Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. This claimant was injured in 2004, now 11 years ago. There is continued pain in both lower extremities, with numbness and tingling to both legs and feet. There were prior MRIs, with latest in 2014. There is spinal degenerative changes. There is no spinal instability noted. In this case, the claimant is well past the acute phase of care. There is no evidence of lumbar spinal instability, or spondylolisthesis. Therefore, this request is appropriately not medically necessary.

MRI of Lumbar Spine: Upheld

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 rationale: As shared, this claimant was injured in 2004, now 11 years ago. There is continued pain in both lower extremities, with numbness and tingling to both legs and feet. There were prior MRIs, with the latest done in 2014. There is spinal degenerative changes. There is no spinal instability noted. There is no objective change in neurologic signs since prior MRI, and the intent of the MRI request was to "update" the prior MRI. Per American College of Occupational and Environmental Medicine Page 303, Low Back Complaints, 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 not medically necessary under the MTUS and other evidence- based criteria.

Continue medication and treatment: Upheld

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, office visits.

Decision rationale: As noted, this claimant was injured in 2004, now 11 years ago. There is continued pain in both lower extremities, with numbness and tingling to both legs and feet. There were prior MRIs, with latest in 2014. There is spinal degenerative changes. There is no spinal instability noted. This is a request to continue medication and treatment, but there were no specifics as to what specifically was being requested. Regarding office visits, the MTUS is silent. The ODG notes that office visits are recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. In this case, it is not clear what functional objective improvements are being achieved, and what would be added by a repeat office visit. The request is appropriately not medically necessary.