Case Number:	CM15-0173790		
Date Assigned:	09/15/2015	**Date of Injury:**	12/03/2012
Decision Date:	10/22/2015	**UR Denial Date:**	08/25/2015
Priority:	Standard	**Application Received:**	09/03/2015

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 43 year old female, who sustained an industrial injury on December 03, 2012. The injured worker was diagnosed as having disc degenerative disc disease not otherwise specified, thoracic outlet syndrome, and myofascial pain and myositis. Treatment and diagnostic studies to date has included physical therapy, status post cervical surgery, and medication regimen. In a progress note dated July 14, 2015 the treating physician reports complaints of constant, burning pain to the back and right arm with symptoms of numbness, weakness, difficulty sleeping, and anxiety. Examination performed on July 14, 2015 revealed trigger points to the upper trapezius, sternocleidomastoid, splenius capitis, and rhomboid muscles bilaterally, decreased cervical lordosis, decreased range of motion to the cervical spine, positive sacroiliac joint compression testing, positive Adson's testing, positive Hawkin's testing, positive speed's test bilaterally, and hyper-pronated stance. On July 14, 2015 the treating physician requested magnetic resonance imaging of the lumbar spine without contrast noting that the injured worker has continued back pain and stiffness along with the treating physician noting weakness on examination. On July 14, 2015 the treating physician requested a spinal Q brace, but the progress note did not indicate the specific reason for the requested equipment. On August 25, 2015 the Utilization Review determined the requests for magnetic resonance imaging of the lumbar spine without contrast and a spinal Q brace to be non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI lumbar spine without contrast: Overturned

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Repeat MRI.

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, MRIs (Magnetic resonance imaging).

Decision rationale: Per the ODG guidelines with regard to MRI of the lumbar spine: Recommended for indications below. MRI's are test of choice for patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy, not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. 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). (Bigos, 1999) (Mullin, 2000) (ACR, 2000) (AAN, 1994) (Aetna, 2004) (Airaksinen, 2006) (Chou, 2007) Magnetic resonance imaging has also become the mainstay in the evaluation of myelopathy. An important limitation of magnetic resonance imaging in the diagnosis of myelopathy is its high sensitivity. Indications for imaging: Magnetic resonance imaging: Thoracic spine trauma: with neurological deficit, 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, other “red flags,” Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. Uncomplicated low back pain, prior lumbar surgery, Uncomplicated low back pain, cauda equina syndrome, Myelopathy (neurological deficit related to the spinal cord), traumatic-Myelopathy, painful-Myelopathy, sudden onset-Myelopathy, stepwise progressive-Myelopathy, slowly progressive-Myelopathy, infectious disease patient-Myelopathy, oncology patient-Repeat MRI: When there is significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). MRI of the lumbar spine dated 10/26/14 found no neural impingement. Per progress report dated 6/22/15, the injured worker complained of constant pain rated 2-3/10 at rest. She did not complain of any pain radiating down her legs. Per progress report dated 7/14/15 the treating physician noted continued back pain and stiffness along with weakness per physical exam. The request is medically necessary.

Spinal Q Brace: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back.

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, Lumbar supports.

Decision rationale: Per the ODG with regard to lumbar supports: Not recommended for prevention. Recommended as an option for treatment. See below for indications. Prevention: Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. (Jellema-Cochrane, 2001) (van Poppel, 1997) (Linton, 2001) (Assendelft-Cochrane, 2004) (van Poppel, 2004) (Resnick, 2005) Lumbar supports do not prevent LBP. (Kinkade, 2007) A systematic review on preventing episodes of back problems found strong, consistent evidence that exercise interventions are effective, and other interventions not effective, including stress management, shoe inserts, back supports, ergonomic/back education, and reduced lifting programs. (Bigos, 2009) This systematic review concluded that there is moderate evidence that lumbar supports are no more effective than doing nothing in preventing low-back pain. (van Duijvenbode, 2008) Treatment: Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option). As there is only very low-quality evidence supporting the use of back braces for the purpose of treatment, the request is not medically necessary.