

Case Number:	CM15-0178161		
Date Assigned:	09/18/2015	Date of Injury:	05/17/2001
Decision Date:	10/21/2015	UR Denial Date:	09/03/2015
Priority:	Standard	Application Received:	09/10/2015

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: North Carolina
 Certification(s)/Specialty: Family Practice

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 68 year old female, who sustained an industrial injury on 5-17-2001. The medical records submitted for this review did not include the details regarding the initial injury. Diagnoses include lumbar disc herniation, radiculopathy, spondylosis, arthritis, thoracic myofascial strain and lumbar degenerative disc disease, status post lumbar fusion. Treatments to date include medication therapy and epidural steroid injections. The medical records documented she complained of increasing low back pain with radiation to the left hip and numbness and tingling to left thigh. The records indicated bilateral L4-S1 selective epidural injections were provided on 4-13-15 that was documented on 5-18-15 to provide 60% relief of pain for a short period of time. On 5-20-15, the physical examination documented decreased sensation to the left anterior thigh. The plan of care included to obtain an MRI of the thoracic spine and rhizotomies of L3-L4. The injured worker was evaluated again on 8-12-15, with no change in subjective complaints or objective findings documented. The plan of care included ongoing medication management and epidural steroid injection to L3-4 and L4-5. The appeal requested authorization for a lumbar spine MRI and rhizotomies at L3-L4. The Utilization Review dated 9-3-15, denied the request citing California MTUS and ACOEM Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Spine MRI: 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: The ACOEM chapter on low back complaints and special diagnostic studies states: 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. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures). Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false positive test results) because of the possibility of identifying a finding that was present before symptoms began and therefore has no temporal association with the symptoms. Techniques vary in their abilities to define abnormalities (Table 12-7). Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Because the overall false-positive rate is 30% for imaging studies in patients over age 30 who do not have symptoms, the risk of diagnostic confusion is great. There is no recorded presence of emerging red flags on the physical exam. There is evidence of nerve compromise on physical exam but there is not mention of consideration for surgery or complete failure of conservative therapy. For these reasons, criteria for imaging as defined above per the ACOEM have not been met. Therefore, the request is not medically necessary.

Rhizotomies at L3-4: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

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

Decision rationale: The ACOEM chapter on low back complaints and treatment options states: There is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provides good temporary relief of pain. Similar quality literature does not exist regarding the same procedure in the lumbar region. Lumbar facet neurotomies reportedly produce mixed results. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. Radiofrequency neurotomy otherwise known as facet rhizotomy has mixed support for use of low back pain per the ACOEM. Therefore, the request is not certified based on ACOEM guidelines and failure of the provided documentation for review to meet criteria. There have been no controlled blocks producing significant pain control. Therefore, the request is not medically necessary.