

Case Number:	CM13-0020796		
Date Assigned:	03/26/2014	Date of Injury:	04/11/2001
Decision Date:	04/24/2014	UR Denial Date:	08/28/2013
Priority:	Standard	Application Received:	09/06/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Management, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient with a date of injury of 4/11/01. The 8/14/13 medical report identifies worsening low back pain with radiating pain progressing into the right leg, which was primarily into the left before. There was been a significant decline in activities of daily living and quality of life, secondary to her symptoms. On exam, there is 3+/5 left knee flexion and extension, dorsiflexion, plantar flexion, and EHL, 4/5 on the right. MRI shows some L1-2 severe disc degeneration with moderate right and left foraminal stenosis with a disc bulge. At L3-4, there was a disc bulge with thickening of the ligamentum flavum resulting in bilateral foraminal stenosis. The patient has a history of L5-S1 transforaminal lumbar interbody fusion in 2010. Recommendations included lumbar epidural steroid injection, and a CT of the lumbar spine to insure that she does not have a pars defect and to assess the fusion at L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT OF THE LUMBAR SPINE WITHOUT CONTRAST: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Decision rationale: The California MTUS does not address CT for this clinical situation. The Official Disability Guidelines support the use of CT to evaluate pars defect not identified on plain x-rays, and to evaluate successful fusion if plain x-rays do not confirm fusion. Within the documentation available for review, there is documentation that the provider wishes to utilize CT to ensure that there is no pars defect and to assess the fusion at L5-S1. However, there is no documentation that x-rays were recently done and failed to identify a pars defect and/or a successful fusion. In the absence of such documentation, the request is not medically necessary.