

Case Number:	CM13-0025235		
Date Assigned:	11/20/2013	Date of Injury:	06/23/1997
Decision Date:	01/23/2014	UR Denial Date:	08/28/2013
Priority:	Standard	Application Received:	09/16/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Neuromuscular Medicine, 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 physician 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:

The patient is a 40 year-old female who sustained an industrial injury on June 23, 1997. The patient is status post lumbar fusion as of March 2000. Prior requests for lumbar CT scan were recommended non-certified in review on 3/26/13, 4/10/13, and 8/21/13. According to clinical notes, subjective complaints we requested authority for an MRI. The degeneration is overt. The musculoskeletal condition will not be evaluated by a competent neurosurgeon without a new MRI of the low back in hand prior to evaluation. This is the standard of care, the advanced degeneration would also support said. She should probably have one every year to every other year. Diagnoses included failed back surgery x 3 and lumbar myofascial pain. On physical examination , flexion is limited to approximately 30 degrees, extension is 10 degrees, rotation is 45 degrees bilaterally. Deep tendon reflexes are +2 bilaterally. Right straight leg raising test is 45 degrees. Left straight leg raising test is approximately 25 degrees with increased pain with dorsiflexion. She has an antalgic gait favoring the left. Per clinical notes, subjective complaints included recent flare for which her usual medicine was insufficient to cover. She is requesting a prescription for Opana for break through pain. Objective findings include significant physical examination, laboratory, imaging, or other diagnostic findings. Objective findings reveal tenderness in the lumbosacral musculature with bilateral myospasms being noted. Lumbar range of motion is restricted markedly in both flexion and extension. Surgical scars are noted. Diagnoses include failed back surgery x 3, lumbar myofascial pain. Per clinical notes provided, a report dated March 10, 2009, relates that the patient has had some low back pain and radiculopathy. The MRI scan that they reviewed today reportedly shows essentially postoperative surgical findings at LS-S1 with no other significant pathologic problems. They do not feel any

IMR ISSUES, DECISIONS AND RATIONALES

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

CT scan lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: The Official Disability Guidelines (ODG) do not recommend computer tomography (CT) scan for multiple diagnoses (please see guidelines for full list). The ODG indicate that magnetic resonance imaging (MRI) has largely replaced computed tomography scanning in the noninvasive evaluation of patients with painful myelopathy because of superior soft tissue resolution and multiplanar capability. In this case, there is no indication from documentation submitted that patient meets these criteria. There is no documentation of recent trauma, neurological deficit, infection, or evidence of recent x-rays. Furthermore the physical examination findings do not reveal evidence of new neurological deficit. Moreover, the ACOEM guidelines for low back states that 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, CT for bony structures. Given the above, the request is noncertified.