

Case Number:	CM13-0055852		
Date Assigned:	10/23/2014	Date of Injury:	01/18/2011
Decision Date:	11/07/2014	UR Denial Date:	09/30/2013
Priority:	Standard	Application Received:	11/21/2013

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 Pain Medicine and Rehabilitation, 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 61 year-old patient sustained an injury on 1/18/11 from slipping on ice while walking toward the truck during employment by [REDACTED]. Request under consideration include CT Scan Lumbar Spine. There is past surgical history of 2 level lumbar fusion (undated); s/p left rotator cuff repair on 4/5/11 and left wrist/humerus surgeries on 1/22/11. Conservative care has included medications, physical therapy (36 visits), occupational therapy (30 visits), lumbar epidural steroid injections, and modified activities/rest. MRI of lumbar spine dated 6/27/11 showed multilevel disc protrusion at L2-3, L3-4, and L4-5 with compression of the dura; hypertrophy at bilateral L5-S1 with neural foraminal narrowing at left L4-S1. Report of 7/1/13 from the provider noted the patient with ongoing worsening chronic left leg radiculopathies radiating to left leg; using foot drop brace for DF/PF weakness. Exam showed well-healed lumbar incision; tenderness to palpation and radiating pain to legs; continued weakness of left leg dorsiflexion of "probably a 2/5." The provider noted CAT scan of the lumbar spine (undated) showed "ongoing fusion of L4-5 and L5-S1, maybe synarthrosis at L5-S1, bone spurs on left L4-5 and L5-S1 foramen but on this CAT scan series they do not look as severe as I would suspect given the patient's symptomatology." Diagnoses were severe persistent left leg radiculopathy s/p two level lumbar fusion. Treatment plan was for lumbar injections with selective nerve blocks. Orthopedic AME report of 8/5/13 noted diagnoses of status post left ORIF of humerus with shoulder arthroscopy for rotator cuff repair and debridement on 4/5/11; status post left wrist ORIF of radial fracture on 1/22/11; and status post lumbar fusion at L4-S1 with laminectomies and neuroforaminotomy on 9/17/12 and revision foraminotomy, microdiscectomy at L4-S1 on 12/22/12. It was opined if the patient's condition deteriorates, future medical provision should include conservative care of oral analgesics and anti-inflammatories, short courses of physical therapy for acute exacerbations, possible trial of

epidurals if warranted by recent EMG/NCS and CT scan, and hardware removal procedure. Report of 9/12/13 from the provider noted the patient with continued chronic severe back pain and left leg radiculopathy. The patient had 6 days of complete relief from pain after the recent LESI but the pain has now returned "full force." Exam of the lumbar spine showed normal lordosis; no scoliosis; well-healed surgical incisions; tenderness to palpation over lower lumbar spine and no evidence of paravertebral muscle spasm; restricted lumbar range of motion. Diagnoses were unchanged noting severe persistent left leg radiculopathy s/p two level lumbar fusion. Treatment included CAT scan of lumbar spine to see the exact anatomy and pathology and SCS to proceed with pain management. The request for CT Scan Lumbar Spine was non-certified on 9/30/13 citing guidelines criteria and lack of medical necessity.

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 ACOEM Page(s): 308-310.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, CT & CT Myelography (computed tomography), pages 383-384.

Decision rationale: The request for CT Scan Lumbar Spine was non-certified on 9/30/13. The patient had recent CAT scan of the lumbar spine as referenced by the provider's 7/1/13 report as with intact fusion with findings not as severe as expected from patient's symptomatology. A subsequent AME report of 8/5/13 deemed the patient P&S and follow-up report of the provider on 9/12/13 had non-progressive unchanged findings to support repeating the imaging study. AME also noted X-rays of lumbar spine showing posterior rods and screws with disc space grafting from L4-S1 in place with flexion-extension views revealing no instability or evidence of new/old fracture or dislocation; oblique views also noted no evidence of defect in pars interarticularis with overall satisfactory osseous density. There was no recommendation for repeating any imaging study. Per ACOEM Treatment Guidelines for Low Back Disorders, under Special Studies and Diagnostic and Treatment Considerations, states Criteria for ordering imaging studies such as the requested CT scan of the Lumbar Spine include emergence of a red flag; Physiologic evidence of tissue insult or neurologic dysfunction; Failure to progress in a strengthening program intended to avoid surgery; Clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination and electrodiagnostic studies. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist; however, review of submitted medical reports have not adequately demonstrated the indication for repeating the CT scan of the Lumbar spine nor document any specific progressive change in clinical findings to support this imaging study recently done. When the neurologic examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. The request for CT Scan Lumbar Spine is not medically necessary and appropriate.