

Case Number:	CM13-0063452		
Date Assigned:	12/30/2013	Date of Injury:	04/01/2011
Decision Date:	04/11/2014	UR Denial Date:	12/02/2013
Priority:	Standard	Application Received:	12/10/2013

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 Family Practice 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 38-year-old female who reported an injury on 04/01/2011. The mechanism of injury was noted to be that while lifting a box, the box started to slip, and the patient twisted her body. The patient had a left L5-S1 epidural steroid injection without benefit and then a left partial laminectomy of L4-5 and L5-S1 on 12/29/2011. The patient had a CT scan of the lumbar spine dated 03/11/2013 and an MRI of the spine on 05/14/2012. The MRI revealed moderate left neural foraminal stenosis at L5-S1 and a possible pseudomeningocele per the documentation of 11/09/2013. The patient had an abnormal nerve conduction study on 11/09/2013, which revealed evidence for decreased amplitude in the left peroneal nerve, showing evidence for an axonal injury at L4-5 and an absent sural sensory showing some evidence of S1 compromise. The electromyogram was a normal examination with no evidence of active denervation changes of the paraspinal muscles. It was indicated that this was changed, as previously the patient had significant irritability of the muscles in the paraspinal muscle region. Per the Qualified Medical Re-Examination of 11/09/2013, the patient may be in need of evaluations by a neurosurgeon should the patient's condition deteriorate further. The neurosurgical progress report dated 10/21/2013 revealed that the patient felt that her leg was weaker and buckling more although it was indicated that the patient made the same statement in August. The physical examination revealed that the patient had very sensitive pain when the physician moved the patient's hip around in abduction or extension and got dramatic pain from the thigh into the lateral hip and back. The patient had absent ankle reflexes and pain-related weakness, and the physician opined that they were not convinced that there was a true weakness in the legs. It was indicated that the patient had not had a CT scan of the lumbar spine to scrutinize the fusion and implants since March, and the physician would recommend a repeat CT scan to verify the fusion. Additionally, the physician indicated that they would recommend an MRI scan to look at the soft tissues in the

discs, including the disc above the L3-4 fusion, which was not completely normal in the beginning. The patient's diagnoses were noted to be low back pain. In the letter sent in appeal on 12/04/2013, the physician indicated that the patient had ongoing pain problems and differential diagnoses including breakdown and progression of stenosis at the level above the fusion, which was in question and could only be answered by a postoperative lumbar MRI scan and potentially radicular left hip pain in the leg that could represent malpositioned hardware or an inadequate fusion, a question that was best answered by a high resolution lumbar CT scan. The request was made for a CT scan and an MRI of the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT scan of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Computed Tomography.

Decision rationale: The MTUS/ACOEM Guidelines state that CT or MRI when cauda equina, tumor or fracture strongly suspected and plain film radiographs are negative(C), MRI test of choice for patients with prior back surgery(D). Furthermore, the Official Disability Guidelines recommend computed tomography to evaluate the success of a fusion if plain x-rays do not confirm a fusion. The clinical documentation submitted for review failed to indicate that the patient had plain x-rays that did not confirm a fusion. Additionally, there was a lack of documentation indicating that the patient had indications for a repeat CT scan as a CT scan was noted to be previously obtained in 03/2013. The official read of the prior CT scan was not provided. Given the above and the lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations, the request for a CT scan of the lumbar spine is not medically necessary and appropriate.

MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Computed Tomography.

Decision rationale: The MTUS/ACOEM Guidelines state that CT or MRI when cauda equina, tumor or fracture strongly suspected and plain film radiographs are negative(C), MRI test of choice for patients with prior back surgery(D). Furthermore, the Official Disability Guidelines recommend a repeat MRI when there is documented evidence that there is a significant change in

symptoms and/or findings suggestive of a significant pathology. The clinical documentation submitted for review failed to provide documentation of an objective myotomal and dermatomal examination to support that the patient had findings suggestive of a significant pathology. There was a lack of documentation indicating that the patient had a significant change in symptoms as the physician documented that the patient had the same statement of leg weakening and buckling more in August. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. The request for an MRI of the lumbar spine is not medically necessary and appropriate.