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| Case Number: | CM13-0067487 | | |
| Date Assigned: | 02/03/2014 | Date of Injury: | 11/02/2012 |
| Decision Date: | 05/27/2014 | UR Denial Date: | 12/10/2013 |
| Priority: | Standard | Application Received: | 12/18/2013 |

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 & 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:

The patient is a 28 year old male who was injured on 11/02/2012. He was unstacking a fiberglass box and he took a few steps backwards and placed the box on the floor. As he stood back up, he heard the sound of an engine from a forklift close by. That is when the lead manager struck him with the forklift in his back. He was thrown forward 6-8 feet and immediately felt sharp pain on his back. Prior treatment history has included medications, physical therapy, and two caudal steroid injections. Diagnostic studies reviewed include x-rays of the lumbar spine dated 03/06/2013 demonstrated evidence of findings most consistent with a pars defect seen at the L5 level without evidence of significant anterolisthesis present. The remaining portion of the lumbar spine is normal. An EMG of the bilateral lower extremities performed on 05/31/2013 shows no electrical evidence of lumbar radiculopathy or any peripheral nerve compression. A PR2 dated 11/18/2013 states the patient complains of constant, severe lower back pain described as sharp, stabbing, radiating, shooting, and achy, increased by bending, twisting, driving, walking, and standing. He has constant, severe pain in the bilateral knee described as sharp, stabbing, radiating, shooting, and achy, increased by driving, walking, standing and kneeling. He has frequent severe bilateral feet pain described as sharp, radiating, shooting, and stabbing, increased by driving, walking, standing, and sitting. He has intermittent severe bilaterally pelvis/hip pain described as achy, sharp, and stabbing, increased by walking, sitting, standing and driving. The patient ambulated with a cane because of her knees. Objective findings on exam revealed tenderness to palpation with limited painful range of motion and positive orthopedic evaluation to the lumbar spine. Diagnosis is lumbar disc with bilateral lower extremity neuralgia; bilateral knee meniscal tear; bilateral leg pain, bilateral foot pain, bilateral hip/pelvic pain; sleep disorder; sexual dysfunction; depressive disorder; and HTN.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-RAY OF 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): 303.

Decision rationale: As per the ACOEM Guidelines, "lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. However, it may be appropriate when the physician believes it would aid in patient management." In this case, this patient reports severe pain in the lower back, bilateral knee, and bilateral feet. The patient is reportedly unable to walk without the use of a cane. There is a prior x-ray done that showed pars defect at L5 level but no evidence of significant anterolisthesis. There is no evidence of red flag pathology such as a fracture or infection. A physical exam also showed no evidence of instability. Thus, the request for x-ray of the lumbar spine is not medically necessary and appropriate.