

Case Number:	CM14-0136001		
Date Assigned:	09/03/2014	Date of Injury:	12/01/1994
Decision Date:	09/25/2014	UR Denial Date:	07/23/2014
Priority:	Standard	Application Received:	08/22/2014

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, has a subspecialty in Interventional Spine 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 65 year old female with an injury date of 12/01/94. Based on 02/14/14 progress report by [REDACTED], the patient presents with chronic low back pain that is severe and debilitating. The pain radiates to bilateral flanks, into bilateral legs with associated numbness and tingling. Patient failed conservative treatment options and has had a spinal cord trial with good results. Previous diagnosis included failed back surgery syndrome. Patient has had medications, physical therapies and injections by appropriate specialists for several years. Physical examination on 02/14/14 states patient has unsteady gait. Lumbar spine has tenderness and severe pain with motion. Per operative report dated 04/03/14 by [REDACTED], patient had a permanent implant of thoracic spinal cord stimulator with somatosensory evoked potentials. Progress report dated 05/08/14 by [REDACTED], mentions that lumbo/sacral spine is guarding and patient ambulates with a cane. Patient came to program spinal dorsal stimulator. Progress report dated 05/29/14 states that patient has increased pain whenever turning spinal dorsal stimulator on. Diagnoses are chronic pain, causalgia of lower limb, thoracic or lumbosacral neuritis or radiculitis, unspecified, post laminectomy syndrome, lumbar region, spinal cord stimulator status. Imaging Studies; 03/11/14 CT Thoracic Spine found the alignment is within normal limits, multilevel degenerative endplate changes with mild anterior osteophyte formation, intervertebral disc spaces are well preserved with no evidence of disc protrusion or bulge, there is no narrowing of spinal canal or neural foramina. 03/27/14 Myelographic CT Thoracic Spine findings comparing to Postarthrographic Thoracic CT: the thoracic cord and thoracic canal are normal. At no level is there any canal mass disc protrusion cord flattening compression or narrowing of the central canal. No wedge compression deformity, there is mild anterior vertebral body spurring. 04/13/14 Thoracic Spine X-Ray: mild atelectasis at left

costophrenic angle, thoracic spinal cord stimulator present [REDACTED] is requesting a Retrospective CT scan of the Thoracic Spine, DOS 12/18/13. The utilization review determination letter being challenged is dated 07/23/14. The rationale is "a repeat CT scan of the thoracic spine was performed on 03/11/14, 3 months after December 2013, and there did not appear to be any significant change. Scan 3 cannot be repeated at 3 month intervals in the absence of progressive neurological change. Medical records reviewed from 12/09/13 - 03/07/14." [REDACTED] is the requesting provider, and she has provided treatment reports from 02/14/14 - 06/27/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective CT Scan of the Thoracic Spine, DOS:12/18/13: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG-TWC guidelines has the following regarding CT scan of L-spine.

Decision rationale: The patient presents with chronic low back pain. The retrospective request is for CT scan of the Thoracic Spine, DOS: 12/18/13. ODG-TWC guidelines has the following regarding CT scan of L-spine: "Indications for imaging -- Computed tomography: thoracic spine trauma: equivocal or positive plain films, no neurological deficit, thoracic spine trauma: with neurological deficit." Per utilization review determination letter dated 07/23/14, the current request would be for a third CT scan repeated at 3 month intervals, without progressive neurological change. Medical records reviewed from 12/09/13 - 03/07/14 determined the decision to deny request. Provided medical reports for this review does not contain any reports that pertain to the issue at hand, CT scan from 12/18/13. There are no reports prior to this date describing any suspicion for fracture, progressive neurologic deficit, infections, tumor or other red flags. There are no discussions provided by the provider as to why a CT scan was needed on 12/18/13. No relevant information is revealed on subsequent visitation notes that would support a CT scan from 12/18/13. Therefore, this request is not medically necessary.