

Case Number:	CM14-0175637		
Date Assigned:	10/28/2014	Date of Injury:	07/20/2010
Decision Date:	12/15/2014	UR Denial Date:	10/07/2014
Priority:	Standard	Application Received:	10/23/2014

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 Occupational 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 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 is a 58year-old male with a 7/20/10 date of injury when he lifted a heavy box and felt pain in his lower back and left leg. The patient was most recently seen on 8/7/14 with complaints of left lower extremity apparent radiculopathy. X-rays performed on that visit reportedly showed five mobile segments, no coronal plane deformity, normal sacroiliac joints, normal hips. The L5-S1 segment is auto-fused on a congenital basis on lateral films. Traction spurs are present t the L4-5 segment. On flexion/extension films there was no translational motion. An MRI from 6/24/13 revealed collapse of the L4-5 disc, anterior and posterior disc protrusion, and mild to moderate neuroforaminal narrowing on the right. Exam findings revealed painfully restricted ranges of motion in the lumbar spine and hips, but an absence of muscle spasm. Straight leg raise was positive on the left at 20-degrees, with pain in the leg, and positive on the right at 40-degrees, with pain in the back. The sitting root test was non-confirmatory. On neurological exam, decreased sensation to light touch was noted in the L5 and S1 distributions on the left. Motor strength was 5/5 throughout, with the exception of the left L5 (ankle dorsiflexors) and left S1 (plantar flexors) which are graded as 4/5 with real weakness, but no wasting. Deep tendon reflexes were absent in the bilateral patellae and bilateral Achilles. The patient's diagnoses included: 1) Spinal stenosis with radiculopathy, lumbar spine. 2) Chronic pain. The medications included: Hydrocodone, Flexeril, zolpidem, Carisprodol, and Sentra AM. Significant Diagnostic Tests: X-rays, and MRI. The treatment to date includes medications. An adverse determination was received on 10/7/14 due to inadequate clinical findings that would justify the use of a CT of the lumbar spine to establish whether chronic nerve damage had occurred, and whether the patient would benefit from surgical intervention.

IMR ISSUES, DECISIONS AND RATIONALES

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

Computed tomography (CT) lumbar spine without dye: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG Low Back Chapter

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

Decision rationale: The ODG criteria for lumbar CT include lumbar spine trauma with neurological deficit; or traumatic or infectious myelopathy; or to evaluate a pars defect not identified on plain x-rays; or to evaluate successful fusion if plain x-rays do not confirm fusion. This patient has been treated for chronic back pain, following a lifting injury 4 years ago. He described ongoing pain of a radicular nature, and showed sensory loss and mild 4/5 motor weaknesses in the left L5 and S1 distributions. A 2013 MRI showed disc collapse and mild to moderate foraminal narrowing on the right side. These findings do suggest a neuropathic cause, or at least component, to this patient's ongoing symptoms. However, the findings are inconclusive, in that in contemplating surgery, the L5-S1 pathology on physical exam must be aligned with the MRI findings of discogenic disease at the L4-5 level. A CT scan of the lumbar spine is likely not the best tool to achieve this goal. Therefore, the request for Computed tomography (CT) lumbar spine without dye is not medically necessary.