

Case Number:	CM14-0182086		
Date Assigned:	11/06/2014	Date of Injury:	03/29/2005
Decision Date:	12/11/2014	UR Denial Date:	10/16/2014
Priority:	Standard	Application Received:	11/03/2014

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 Orthopedic Surgery, 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 38-year-old male sustained an industrial injury on 3/29/05. The mechanism of injury was not documented. Past surgical history was positive for lumbar fusion and cervical discectomy. The patient was reported status post removal of L3/4 and L4/5 instrumentation on 6/7/11. Records indicated the patient had chronic cervicalgia, chronic intractable lumbar backache, history of lumbar surgery, bilateral upper and lower extremity radiculopathy pain, and recurrent myofascial strain. He was dependent on medications (Norco and topical compounds) and activity modifications. The 9/21/14 treating physician progress report cited chief complaint of right-sided lower back pain. Physical exam documented well-healed incision. The patient was to continue his current level of activities as tolerated. Authorization was requested for CT scan of the lumbar spine and x-rays of the lumbar spine with flexion and extension views. The 10/16/14 utilization review denied the request for lumbar spine CT scan and x-rays as there was insufficient information to determine the medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT lumbar scan: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for imaging; Plain X-rays, Magnetic resonance imaging, Progressive neurologic deficit.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 59.

Decision rationale: The California MTUS revised low back guidelines do not recommend routine CT scan for acute, sub-acute or chronic non-specific lower back pain, or for radicular pain syndromes. CT scan is recommended for patients with an indication for MRI who cannot complete the MRI due to contraindications such as implanted metallic-ferrous device or significant claustrophobia. Guidelines state that repeat lumbar imaging without significant clinical deterioration in symptoms and/or signs is not recommended. Guideline criteria have not been met. There is no evidence that this patient has experienced a significant change in symptoms or clinical deterioration in signs/symptoms to support the medical necessity of repeat imaging at this time. Therefore, this request is not medically necessary.

x-rays lumbaar spine series: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for imaging Plain X-rays, Magnetic resonance imaging, Progressive neurologic deficit.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 50-51.

Decision rationale: The California MTUS revised low back guidelines recommend X-rays for chronic lower back pain as an option to rule-out other possible conditions. Flexion/extension views are recommended for evaluating symptomatic spondylolisthesis in which there is consideration for surgery or other invasive treatment. Guideline criteria have not been met. This patient presented with right sided lower back pain with no current detailed comprehensive physical exam findings to support the medical necessity of radiographic evaluation at this time. There was no medical rationale presented to support the medical necessity of this request. Therefore, this request is not medically necessary.