

Case Number:	CM14-0021581		
Date Assigned:	05/07/2014	Date of Injury:	10/21/2001
Decision Date:	07/09/2014	UR Denial Date:	01/24/2014
Priority:	Standard	Application Received:	02/20/2014

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 Neuromuscular Medicine and is licensed to practice in Maryland. 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 50 year old female who had a work injury dated 10/21/01. The patient underwent a L5-S1 fusion and subsequent hardware removal in the past. Her diagnoses include lumbar post laminectomy syndrome, lumbar radiculopathy, myalgia, shoulder joint pain. Treatment has included medications, physical therapy and spinal cord stimulator. There is a request for the medical necessity of a lumbar CT. There is a 1/6/14 office visits which states that the patient states that her left lower extremity pain is getting worse with more burning pain. She reports difficulty with her spinal cord stimulator. She has increased pain in the left leg in an L4 distribution and a lumbar CT with and without contrast was the treatment plan which the documenting physician states was to see if there is something new catastrophic going on in her spine. Because of the increasing neuropathic radicular symptoms, the provider was not decreasing her medications. On physical exam, the patient's gait was very antalgic. There is pain and difficulty with transfers from sitting to standing. She ambulates with a cane. Her bulk and tone are grossly normal. There is decreased light touch sensation in a left L4 distribution and decreased range of motion for flexion and extension. There is paraspinal muscle tenderness with spasm. Her range of motion was grossly normal for major joints.

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: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309. Decision based on Non-MTUS Citation ODG, Low Back Chapter, CT.

Decision rationale: The ACOEM MTUS guidelines state that a CT or MRI can be required if tumor, trauma or infection are suspected if plain radiographs are negative. The ODG guidelines states that a lumbar CT is indicated in trauma, seat belt fracture, traumatic or infectious myelopathy, if there is a pars defect suspected not seen on plain x-rays and to evaluate a successful fusion if plain x-rays do not confirm fusion. The documentation submitted does not indicate evidence of a new trauma, suspicion of injection or myelopathy. The physical exam findings have been relatively stable and the patient has chronic pain. There is no evidence that patient has recent lumbar radiographs on documentation submitted. The request for a lumbar CT is not medically necessary.