

Case Number:	CM14-0042793		
Date Assigned:	06/30/2014	Date of Injury:	06/08/2000
Decision Date:	07/31/2014	UR Denial Date:	03/26/2014
Priority:	Standard	Application Received:	04/09/2014

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 Internal Medicine, has a subspecialty in Pulmonary Diseases 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 injured worker is a 44-year-old male who reported an injury on 06/08/2000, with the mechanism of injury not cited within the documentation provided. In the clinical notes dated 03/10/2014, the injured worker complained of worsening back pain that radiated down his right leg with muscle spasms. The injured worker rated his pain level status at 9/10 with the best being 8/10 with medications and worst 10/10. It was annotated that the injured worker stated the medications are helpful and at least 50% increase in function with medications. Prior treatments included anterior spinal fusion from L5-S1 and prescribed medications. The injured worker's prescribed medication regimen included Lyrica 300 mg, Ambien, Aciphex, ranitidine, Abilify, Cymbalta, MS Contin, and Norco. The physical examination of the lumbar spine revealed muscle spasms upon palpation, forward flexion of 20 degrees, altered sensory loss at the right lateral calf and bottom of his foot. The diagnoses included flare up of back pain; history of anterior spinal fusion from L5-S1 with discogenic pain; history of MRSA staph infection at an abdominal wound incision site, stable following anterior spinal surgery approach; depression with industrial onset stable with psychotropic medications per above; neuropathic burning pain in the lower extremities stable with Lyrica; history of migraine headaches, hyperlipidemia, peptic ulcer disease, bilateral knee pain, left shoulder pain, left knee arthroscopy and degenerative joint disease and status post hemorrhoidectomy, all nonindustrial. The treatment plan included a refill of MS Contin 30 mg and Norco 10/325 mg and a request for an updated MRI scan with and without contrast of his lumbar, as well as a CT scan to make sure the injured worker's fusion status was stable. The request for x-rays of the lumbar spine with flexion/extension views was also made.

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: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The CA MTUS/ACOEM Guidelines state that unequivocal objective findings that identify specific nerve compromise on a neurologic examination are sufficient evidence to warrant imaging in injured workers who do not respond to treatment and who would consider surgery an option. When the neurologic exam is clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminate imaging will result in false positives, such as disc bulges that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging for neuro or other soft tissue, computer tomography (CT) for bony structures). In the clinical notes provided for review, there is a lack of documentation of the injured worker presenting with new symptoms such as neurological/functional deficits. Furthermore, there is a lack of documentation of the injured worker having failed a home exercise program or the use of other conservative treatment modalities such as NSAIDs or heat/cold therapy. Therefore, the request for CT scan of the lumbar spine is not medically necessary.