

Case Number:	CM14-0057378		
Date Assigned:	07/09/2014	Date of Injury:	07/01/1994
Decision Date:	08/08/2014	UR Denial Date:	03/24/2014
Priority:	Standard	Application Received:	04/28/2014

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 and Rehabilitation and is licensed to practice in Texas and Ohio. 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 78-year-old male with a reported date of injury of 07/01/1994. The mechanism of injury was not submitted within the medical records. His diagnoses were noted to include postlaminectomy, decompression, disc replacement, arthroplasty at L5-S1, and fusion at L4-5. His previous treatments were noted to include surgery, medications, an epidural injection and exercise. The progress note dated 10/24/2013 noted the injured worker complained of pain in his mid-back and had difficulty standing and doing dishes. The injured worker also reported his legs felt heavy when he walked several blocks and some pain to his right knee. The physical examination showed difficulty walking on heels and toes. The injured worker could forward flex, touching his hands to his knees, and sensation was intact at the distribution of L4, L5, and S1 bilaterally. The provider reported he had absent ankle jerks and his knee jerks were present. The injured worker had reasonable good strength of dorsiflexion of his foot and great toe, as well as eversion of his foot and ankle. A computed tomography (CT) scan performed 03/24/2010 indicated dextroscoliosis with degenerative disc disease and facet arthropathy and retrolisthesis L1-2, L2-3, and anterolisthesis L3-4 with extensive postoperative changes, canal stenosis including L1-2, mild to moderate canal stenosis, neural foraminal narrowing including L1-2, severe left, moderate right, L2-3 and L3-4 severe bilaterally, and L4-5 moderate to severe bilateral neural foraminal narrowing. The request for authorization form dated 03/18/2014 was for a CT scan of thoracic (T) 12-sacral (S) 1 reconstructed sagittal and coronal views due to back pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Computed Tomography (CT) Scan Thoracic 12- Sacral 1 reconstructed sagittal and coronal views: 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 injured worker has had a previous CT scan in 03/2010. The California MTUS ACOEM Guidelines state if there is unequivocal objective findings that identify specific nerve compromise on a neurological examination, this is sufficient to warrant imaging in injured workers who do not respond to treatment and who would consider surgery an option. When the neurological examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminate imaging would result in false positive findings, 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 identify a potential cause, such as a CT for bony structures. The guidelines state a CT scan can be used to identify and define low back pathology in regards to disc protrusion, cauda equina syndrome, spinal stenosis, and postlaminectomy syndrome. The documentation provided reported an x-ray to the lumbar spine taken on 10/24/2013, which revealed stable implantation, disc replacement, from L5-S1; fusion from L4-5; and mild lumbar scoliosis. The documentation provided did not indicate the injured worker had attempted conservative treatment and failed prior to the examination on 10/2013. The guidelines recommendation is 4-6 weeks of conservative treatment modalities before a CT scan when radicular pain is not demonstrated. Therefore, the request is not medically necessary.