

Case Number:	CM14-0109840		
Date Assigned:	09/16/2014	Date of Injury:	08/17/2011
Decision Date:	01/30/2015	UR Denial Date:	07/07/2014
Priority:	Standard	Application Received:	07/15/2014

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 Family Practice, and is licensed to practice in New Jersey. 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 33 year old male was an order puller when he sustained an injury on Aug 17, 2011. He injured his lower back while wrapping pallets. Past treatment included diagnostic studies, pain and muscle relaxant medications, right sacroiliac joint and lumbar epidural steroid injections that provided relief, activity modifications, acupuncture, physical therapy, and chiropractic therapy. On September 28, 2012, an MRI revealed a herniated disc which mildly pressed on the thecal sac at L2-3 level and left side sacralisation at L5. On January 16, 2014, x-rays of the lumbar spine were done to rule out a herniated nucleus pulposus. The x-rays revealed mild degenerative disc disease at L2-3 only. On May 20, 2014, the primary treating physician noted lumbar spine pain and radicular pain in the bilateral lower extremities. The injured worker reported that his condition had slightly worsened. The physical exam revealed tenderness to palpation of the lumbar spine paravertebral muscles. There were positive spasms, guarding, trigger points, and twitch response in the paravertebral muscles. The neurological responses remained unchanged. Diagnoses were musculoligamentous sprain, neuritis, radiculitis, and a herniated ruptured disc of the lumbar spine. The physician noted the injured worker was waiting for a neurosurgical consult for possible surgical intervention. The physician documented that the injured worker had failed conservative care. The physician recommended pain and proton pump inhibitor medications and 6 visits of physical therapy. The injured worker was to remain off work. On May 20, 2014, the secondary treating physician noted intermittent lower back pain that becomes slight to moderate with activities of daily living. The physical exam revealed positive Yeoman's, tenderness of the lumbar spine paraspinals, and normal range of motion. The treatment plan included continued physical and chiropractic therapy with electrical muscle stimulation, massage, myofascial release, mobilization, and work conditioning to the lumbar spine. The secondary treating physician noted the injured worker was making slow and steady progress. On 6/30/14, a request

for a lumbar CT scan was submitted by the worker's neurosurgeon. No progress note from around the time of this request and by the requesting physician (neurosurgeon) was submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Computed tomography scan of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 296-310.

Decision rationale: MTUS Guidelines for diagnostic considerations related to lower back pain or injury require that for any special imaging study to be warranted there needs to be unequivocal objective clinical findings that suggest red flag diagnoses (cauda equina, infection, fracture, tumor, dissecting/ruptured aneurysm, etc.), and only in those patients who would consider surgery as an option to correct it. In non-emergent situations, a failure of conservative treatments for at least 4-6 weeks is required before considering any imaging. In some situations where the patient has had prior surgery on the back where the physician is looking for stability of a fusion surgery, for example, or there is a suspected bony abnormality such as fracture, CT scan may be considered. In the case of this worker, there was no evidence to suggest a CT scan was indicated (no red flag signs/symptoms, etc.) and the submission of the request was by the worker's neurosurgeon, for which there was no supporting documentation of their encounter and the context in which the request for the CT scan was made. Therefore, due to lack of background information and essentially no evidence to support the CT scan, it will be considered medically unnecessary at this time.