

Case Number:	CM14-0186425		
Date Assigned:	11/14/2014	Date of Injury:	05/05/2014
Decision Date:	01/05/2015	UR Denial Date:	10/30/2014
Priority:	Standard	Application Received:	11/10/2014

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 Spinal Surgeon, and is licensed to practice in New York. 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 a 45-year-old male with a work related history dated May 5, 2014 with a back injury sustained. Per the documentation of the treating physician's visit on October 17, 2014, the worker had tenderness to palpation bilaterally about the lumbar paraspinal musculature. The worker was very guarded in motion of the thoracolumbar spine with severely limited range of motion. Flexion of the area was restricted to forward flexion of 20 degrees, extension 10 to 15 degrees and right lateral bending 5-10 degrees before stopping with complaints of pain. Motor examination was felt to be normal in all major muscle groups of the lower extremities. Sensory examination was normal to light touch. Magnetic resonance imaging results documented by the physician reflected a central disc protrusion at the L3-4 with mild degenerative changes resulting in mild to moderate canal stenosis and mild bilateral foraminal stenosis at the L3-4 and the L4-5. These results reflected that surgical intervention was not likely to support good results. Diagnosis recorded on the authorization request was the diagnosis of lumbar stenosis. Treatment to date has included physical therapy, epidural injections with some relief and pain medication. Based on the physical exam and history of subjective complaints, an authorization for a computed tomography and myelogram of the lumbar spine was requested to determine possible causes for continued pain. The UR determination dated October 30, 2014 reflected the computed tomography and myelogram of the lumbar spine was not authorized. Per the documentation the guidelines specific for computed tomography myelogram did not support that the worker had a well-defined radiculopathy in a specific dermatomal pattern and thus there was no indication that the magnetic resonance imaging scan is of sub optimal quality.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar CT scan plus Myelogram: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 178. Decision based on Non-MTUS Citation ODG, Criteria for Myelography and CT Myelography

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-322. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ODG low back chapter

Decision rationale: Magnetic resonance imaging results documented by the physician reflected a central disc protrusion at the L3-4 with mild degenerative changes resulting in mild to moderate canal stenosis and mild bilateral foraminal stenosis at the L3-4 and the L4-5. The medical records do not substantiate the need for additional CT myelogram testing in this case. The medical records clearly documented that the MRI shows specific pathology in the lumbar spine. In addition there is no correlation between physical examination findings and the patient's MRI. The medical records do not document any quality concerns with respect to the MRI. The MRI appears to show lumbar degenerative pathology and additional CT myelographic image is not medically necessary as the pathology in the lumbar spine is early shown clearly on the MRI. Also, the patient's physical examination does not correlate with the MRI imaging studies showing radiculopathy that correlates with compression on imaging. Additional CT myelographic testing is not medically necessary.