MAXIMUS Federal Services

Case Number:	CM14-0190959		
Date Assigned:	11/24/2014	Date of Injury:	04/10/1997
Decision Date:	01/09/2015	UR Denial Date:	11/05/2014
Priority:	Standard	Application Received:	11/17/2014

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 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 60 year old female continues to complain of low back and bilateral leg pain stemming from a work related injury reported on 4/10/1997. This fall injury resulted in 5 right knee surgeries; an implantation of a spinal cord stimulator to help control pain; and surgical scar pain after lumbar surgery for which inter-body fusions were done and hardware placed, and requiring injections with follow-up post-surgical diagnostic imaging. Diagnoses included lumbago-degeneration of lumbar or lumbosacral intervertebral disc; post-laminectomy syndrome of lumbar region; thoracic or lumbosacral neuritis or radiculitis unspecified; mononeuritis of lower limb unspecified; infection and inflammation reaction due to internal joint prosthesis; lumbosacral spondylosis without myelopathy; osteoarthritis generalized or localized - involving pelvic region and thigh; and spinal stenosis of lumbar region without neurogenic claudication. Treatments have included consultations; diagnostic laboratories, imaging studies and bone scan; multiple surgeries with follow-up diagnostic imaging and studies; and medication management. Orthopaedic progress notes, dated 8/4/2014, do not state subjective complaints of pain. Objective examination findings note the injured worker (IW) is getting bilateral leg pain and that she is neurologically intact with good reflexes and strength. Low back x-rays are stated to show a fusion; hardware at lumbar (L) 4 - L5 and L5- sacral (S) 1 with inter-body fusions solid L3 - sacrum; and notes degeneration at L2-L3. The plan included the desire to get a total body scan to evaluate her back as it had been bothering her a lot more, and to determine if she has stenosis at "this" level that would account for her leg pain.Urine drug screen results, collected 8/5/2014, were noted. The pain management PR-2 report, dated 9/2/2014, is hand written and mostly illegible for information for my review. The pain management PR-2, dated 9/30/2014, is also hand written and mostly illegible, but legible enough to note that the IW returned with complaints of back pain when she lies on her back, that certain positions cause cramping of legs,

and that she has poor tolerance of sitting. The IW complained of pinching pain and electrical shock to the right lower extremity and buttock. Objective findings note a rash to the left knee with "no n/v/d/c/ssg SE3; no side effects to meds and decreased range of motion to the lumbar spine with no motor or sensory deficits". Hand written margin notes include "pain level: 7/10 w/meds, 10/10 w/out meds, aberrant behavior". The treatment plan included: "1) med home representative met with pt (patient) for reprogramming; 2) PR 1 month; 3) still awaiting CT scan as per [redacted]; 4) continue with SCS; and 5) continue with Norco, Cymbalta". The pain management PR-2, dated 10/27/2014, hand written and mostly illegible, notes subjective complaints of right groin and right leg pain that radiated into the foot, along with complaints of low back burning pain, increased pain with sitting too long, and positive (illegible) pain. Objective examination findings note "negative n/v/d/c/cp/sob". Margin notes include "meds: Norco Cymbalta, Lyrica", "pain score 10/10 without meds, pain with meds 7/10, and no aberrant behavior". The treatment included: "1) continue with Norco, Cymbalta, Lyrica no changes; 2) RTC 1 month; 3) Pt (patient) f/u w/CT scan/bone scan denial from [redacted]; 4) UDS done 8/5/14 WNL". A Medtronic Neuromodulation report, dated 9/30/2014, noted a diagnosis of failed back syndrome.Noted are handwritten, mostly illegible, PR-2 documents from 7/2/2014, 6/6/2014 and 5/7/2014, but no further medical records are available for my review. On 11/5/2014, Utilization Review non-certified, for medical necessity, a request for a CT scan of the lumbar spine. The reason cited was that there were no recent objective documented findings of the lumbar spine and that the 8/4/2014 objective findings did not suggest significant lumbar pathology or severe neurologic deficit that would warrant a CT scan. No findings to support suspicion of cauda equine, tumor, infection or fracture were noted to meet the recommendations set forth by MTUS and ACOEM for low back complaints, to warrant meet the request.The injured worker is a 60-year-old female who reported an injury on 04/10/1997. The mechanism of injury was due to a fall. The injured worker has a diagnoses of lumbago; degeneration of lumbar or lumbosacral intervertebral disc; post laminectomy syndrome of lumbar region; thoracic or lumbosacral neuritis or radiculitis, unspecified; mononeuritis of the lower limb, unspecified; lumbosacral spondylosis without myelopathy; osteoarthritis generalized or localized; and spinal stenosis of the lumbar region without neurogenic claudication. Past medical treatment consists of surgeries, physical therapy, and medication therapy. Medications include Norco, Cymbalta, and Lyrica. A urine drug screen was obtained on 08/05/2014, showing that the injured worker was compliant with prescription medications. On 10/27/2014, the injured worker complained of right groin and right leg pain that radiated into the foot, along with complaints of low back burning pain, increased pain with sitting for long periods of time. Upon physical examination, the injured worker rated the pain a 10/10 without medications, and a 7/10 with medications. Lumbar spine range of motion was decreased. It was also documented that the injured worker had a non-antalgic gait. There were positive signs N/V/D/C/CP/SOB. The medical treatment plan is a decision for 1 CT scan of the lumbar spine between 11/03/2014 and 12/18/2014. The rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 CT scan of the lumbar spine between 11/3/2014 and 12/18/2014: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), On-Line Edition Chapter: Low Back - Lumbar & Thoracic (Acute & Chronic), CT (computed tomography)

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

Decision rationale: The request for 1 CT scan of the lumbar spine between 11/3/2014 and 12/18/2014 is not medically necessary. The California MTUS/ACOEM Guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic exam are sufficient evidence to warrant imaging in patients who do not respond to treatment. However, it is also stated that when the neurologic examination is less clear, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Documentation revealed that the injured worker had complaints of right groin and right leg pain that radiated into the foot. However, there was no indication of the injured worker being positive for tenderness to palpation of the lumbar spine; there was also no evidence regarding conservative treatment. The hand written, mostly illegible, progress note dated 10/27/2014 revealed no pertinent physical examination findings showing any functional deficits the injured worker was having. There were no motor strengths, sensory deficits, or range of motion documented. In the absence of the documentation, a CT is not supported by the referenced guidelines. As such, the request is not medically necessary.