

Case Number:	CM14-0194330		
Date Assigned:	12/02/2014	Date of Injury:	11/01/2003
Decision Date:	01/14/2015	UR Denial Date:	11/08/2014
Priority:	Standard	Application Received:	11/20/2014

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, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 patient is a 45-year old male with a work injury dated 11/1/03. The diagnoses include lumbosacral spondylosis without myelopathy. Under consideration are requests for 1 CT scan of the lumbar spine without contrast and 1 Referral to [REDACTED]. An 11/20/13 EMG/NCS revealed generalized peripheral neuropathy with no evidence of lumbosacral radiculopathy in the bilateral lower extremities. There is a 9/1/8/14 progress note that states that the patient presents for follow up on low back pain. His pain is a 5/5 level which has been worsening over the past month. He has no new symptoms. The pain will radiate to the posterior right knee and lower leg at times but not today. He has no bowel/bladder incontinence. He feels there may be something wrong with his spinal cord stimulator. On exam his gait is antalgic both sides with no assistive device. There are no lumbar muscle spasms. There is paraspinous lumbar tenderness. His lower extremity strength is slightly diminished but symmetrical. He has decreased painful lumbar range of motion. His bilateral knee, ankle and foot strength are decreased. There is no decreased sensation to light touch in the bilateral lower extremities. Motor strength is normal. Unable to test right Achilles reflex secondary to his sensitivity from previous skin grafts. Patella reflex is 3+ and Achilles is 3+ on the right. The treatment plan states that he has disc disease at multiple levels and may be a candidate for epidural injections. A CT was ordered because he has a spinal cord stimulator and it may visualize his facets better which may be contributing to pain. He will maintain his current medications.

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 without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 59, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic)- CT (computed tomography)

Decision rationale: 1 CT scan of the lumbar spine without contrast is not medically necessary per the MTUS and the ODG guidelines. The MTUS ACOEM guidelines state that 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 [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). The ODG states that a lumbar CT is not necessary unless there is lumbar trauma, myelopathy, a pars defect not identified on x-rays, or status post fusion if x-rays do not confirm a successful fusion. The documentation does not indicate new trauma or physical exam evidence of myelopathy or a possible pars defect on x-rays. There are no supporting physical exam findings which necessitate the addition of lumbar CT scanning. The documentation indicates that the patient has a history of peripheral polyneuropathy diagnosed through Electrodiagnostic testing. The most recent progress note reports that the patient has no new symptoms. The most recent physical exam findings reveal conflicting documentation on muscle strength testing stating that the patient's strength in the lower extremities is decreased and then stating that the motor exam is normal. There is additional conflicting testing of the Achilles reflex. There is no evidence of a positive straight leg raise. Due to the conflicting physical exam findings which are not significantly changed from prior progress notes the request for CT of the lumbar spine without dye is not medically necessary.

1 Referral to [REDACTED]: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 92. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain- Office visits

Decision rationale: 1 Referral to [REDACTED] is not medically necessary per is not medically necessary per the MTUS ACOEM and the ODG guidelines. The MTUS states that a referral may be appropriate if the practitioner is uncomfortable with the line of inquiry outlined above, with treating a particular cause of delayed recovery (such as substance abuse), or has difficulty obtaining information or agreement to a treatment plan. The ODG states that the need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The

documentation is not clear on the need for a pain management consultation. The documentation does not reveal objective findings of radiculopathy. The documentation indicates that the patient has stable chronic low back pain and a history of peripheral polyneuropathy. The most recent progress note reports that the patient has no new symptoms. The most recent physical exam findings reveal conflicting documentation on muscle strength testing stating that the patient's strength in the lower extremities is decreased and then stating that the motor exam is normal. There is additional conflicting testing of the Achilles reflex. There is no evidence of a positive straight leg raise. Due to the conflicting physical exam findings which are not significantly changed from prior progress the request for 1 referral to [REDACTED] is not medically necessary.