

Case Number:	CM14-0197797		
Date Assigned:	12/08/2014	Date of Injury:	09/26/2002
Decision Date:	01/23/2015	UR Denial Date:	11/13/2014
Priority:	Standard	Application Received:	11/25/2014

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 Surgery and is licensed to practice in Georgia. 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 61-year-old female who reported an injury on 09/26/2002. The mechanism of injury was pushing. Her diagnoses were noted to include post laminectomy syndrome, lumbago, and lumbar radiculitis. The injured worker's past treatments included physical therapy, TENS unit, and medications. The injured worker's diagnostic testing included an MRI of the left knee without contrast performed on 09/15/2014, which was noted to reveal partial discoid at the lateral meniscus, with intrasubstance degenerative signal, medial compartment chondromalacia, and chondromalacia patella. A CT of the lumbar spine was noted to reveal solid fusion at L3-S1 without hardware failure. The injured worker's surgical history was noted to include shoulder arthroscopy, posterior fusion L3-S1, SCS implant, left knee arthroscopy, and right knee arthroscopy. On 11/11/2014, the patient complained of blood pressure. She reported pain in both legs, but no weakness. She continued to use a variety of medications, including Norco and Lyrica, which she stated still helped her pain. Upon physical examination, the patient was noted with diffuse pain present to palpation of the low back, including over the posterior midline lumbar scar, extending from the L3 to the sacrum, as well as the adjacent paraspinal musculature. The lumbar spine range of motion was limited with moderate pain. The patient was better, with a positive straight leg raise bilaterally. The patient was noted to be neurologically intact. Strength was normal in the lower extremities, except for reduced at bilateral ankle PF/DF at 5-/5. The injured worker's medications included Celebrex 200 mg, Cymbalta 200 mg, Lidoderm 5% patch, Lyrica 100 mg, Norco 10/325 mg, Trazodone 150 mg, and Voltaren XR 100 mg. The request was for CT (computed tomography) with reconstruction of lumbar spine without contrast. The rationale for the request was not clearly provided. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT (computed tomography) with reconstruction of lumbar spine without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, CT (computed tomography)

Decision rationale: The request for CT (computed tomography) with reconstruction of lumbar spine without contrast is not medically necessary. According to the California MTUS/ACOEM Guidelines, unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. More specifically, the Official Disability Guidelines state CT may be recommended for suspected spine trauma, then section CT examination with multiplanar reconstructive images may be recommended. The documentation indicates the patient underwent a CT of the lumbar spine in 01/2014. The documentation does not provide sufficient evidence of significant progressive neurological deficits or new onset of significant objective neurological symptoms. In the absence of documentation with sufficient evidence of significant objective progressive or new neurological deficits since previous CT of the lumbar spine, the request is not supported. Therefore, the request is not medically necessary.