MAXIMUS Federal Services

Case Number:	CM15-0142177		
Date Assigned:	08/03/2015	Date of Injury:	09/08/2009
Decision Date:	08/31/2015	UR Denial Date:	06/25/2015
Priority:	Standard	Application Received:	07/22/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: North Carolina
Certification(s)/Specialty: Family Practice

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 is a 52 year old male with a September 8, 2009 date of injury. A progress note dated April 22, 2015 documents subjective complaints (lower back pain on the right side which is slowly getting worse; some referred pain which radiates straight to the back of the thighs; worst pain score of 10 out of 10, least pan score of 5 out of 10, and usual pain score of 7 out of 10; bilateral lower back pain; pain into the upper posterior right leg and into the right buttock), objective findings (in moderate discomfort; pain behavior present; lump on right forearm; mildly increased thoracic kyphotic curvature; facet tenderness bilaterally; positive facet loading test bilaterally; sacroiliac joint tenderness on the right; sciatic notch tenderness present bilaterally; restricted spine extension with pain on the right; slow, antalgic gait; piriformis tenderness on the right; unable to stand on toes or heels), and current diagnoses (chronic pain syndrome; lumbosacral spondylosis without myelopathy; degeneration of lumbar or lumbosacral intervertebral disc). Treatments to date have included radiofrequency lesioning that gave pain relief for two months, medications, lumbosacral facet joint injections, diagnostic medial branch block, physical therapy, massage therapy, imaging studies, and psychotherapy. The treating physician documented a plan of care that included computed tomography scan of the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT scan lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

Decision rationale: 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 and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. 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, computed tomography [CT] for bony structures). Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false positive test results) because of the possibility of identifying a finding that was present before symptoms began and therefore has no temporal association with the symptoms. Techniques vary in their abilities to define abnormalities (Table 12-7). Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Because the overall false-positive rate is 30% for imaging studies in patients over age 30 who do not have symptoms, the risk of diagnostic confusion is great. There is no recorded presence of emerging red flags on the physical exam. There is evidence of nerve compromise on physical exam but there is not mention of consideration for surgery or complete failure of conservative therapy. For these reasons, criteria for imaging as defined above per the ACOEM have not been met. Therefore, the request is not medically necessary.