

Case Number:	CM14-0114545		
Date Assigned:	08/04/2014	Date of Injury:	11/15/2011
Decision Date:	10/16/2014	UR Denial Date:	06/30/2014
Priority:	Standard	Application Received:	07/21/2014

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 Internal Medicine, and is licensed to practice in California. 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 an injured worker with the diagnoses of lumbar spine disc herniation, lumbar spine degenerative disc disease and facet arthropathy, and lumbar radiculopathy. Date of injury was 11-15-2011. Mechanism of injury was trip and fall. The primary treating physician progress report dated 4/23/14 documented subjective complaints of low back pain. On 4/23/14, the patient presented for follow-up of low back complaints. Since the last visit his condition has remained stable with persistent pain complaints, which can be severe at times. He is not currently working and last worked April 2012. He is not receiving any chiropractic, acupuncture, or physical therapy treatment at this time. In regards to medication, he takes Ibuprofen 5 tablets per day. The patient states he has constant aching and stabbing low back pain, equal both sides that he rates at 7-8/10 on the pain scale. He does have numbness, tingling, and weakness along the posterior aspect of the right leg, but denies any numbness, tingling, weakness, or pain in bilateral lower extremities at this time. Physical examination was documented. The patient is alert and oriented, in no acute distress. Gait was mildly antalgic. Heel and toe walk is normal. Tenderness in bilateral facet regions at L4-5 and L5-S1. Range of motion the lumbar spine demonstrated flexion 45 degrees and extension 10 degrees. Motor 5-/5 right tibialis anterior and extensor hallucis longus. Reflexes were hyper reflexive bilaterally in the patella, and normal bilateral Achilles. Babinski and clonus are negative bilaterally. SLR straight leg raise test is negative bilaterally. Slump test is negative bilaterally. Positive facet challenge bilaterally at L5-S1. Physical examination is consistent with radiculopathy, including sensory and motor deficits. MRI of the lumbar spine performed 1/13/2012 documented mild chronic degenerative disc disease of the lumbar spine; L3-4 3 mm disc bulge; mild central canal stenosis; L4-5 minimal disc bulge with mild central canal narrowing; L5-S1 grade 1 Anterolisthesis with mild disc bulge, no significant central canal stenosis, minimal neural foraminal narrowing. There are disc

protrusions at L3-4, L4-5, and L5-S1. There is stenosis at L3-4, L4-5, and L5-S1. The pars interarticularis is difficult to evaluate by the treating physician. Diagnoses were lumbar spine disc herniation, lumbar spine degenerative disc disease and facet arthropathy, and lumbar radiculopathy. Treatment plan included a request for a CT scan of the lumbar spine to evaluate for a pars interarticularis defect. Progress report dated 1/22/14 documented that a seven view lumbar spine x-ray series showed L5 Anterolisthesis and multilevel moderate disc space narrowing. There were large anterior osteophytes at multilevels. There was facet arthropathy noted at bilateral L5 and S1 levels. CT scan of the lumbar spine was requested to evaluate the bony anatomy not seen well on the MRI. The patient has a L5-S1 spondylolisthesis and a pars defect is possible. Utilization review determination date was 6/30/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT scan lumbar spine: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back (updated 06/10/14) CT

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) CT (computed tomography)

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses imaging for low back conditions. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints states that objective findings that identify nerve compromise are evidence to warrant imaging. CT is recommended when tumor, infection, or fracture is strongly suspected and plain film radiographs are negative. Official Disability Guidelines (ODG) state that CT (computed tomography) is indicated to evaluate pars defect not identified on plain x-rays. The primary treating physician's progress report dated 4/23/14 documented that the pars interarticularis was difficult to evaluate on the 1/13/12 MRI of the lumbar spine. The seven view lumbar spine x-ray series performed on 1/22/14 showed L5 Anterolisthesis and multilevel moderate disc space narrowing. There were large anterior osteophytes at multilevel. There was facet arthropathy noted at bilateral L5 and S1 levels. The patient has a history of traumatic injury to the lumbosacral spine. Physical examination was consistent with radiculopathy, including sensory and motor deficits. CT scan of the lumbar spine was requested to evaluate the bony anatomy not seen well on the MRI. The patient has a L5-S1 spondylolisthesis and a pars defect is possible. CT scan of the lumbar spine was requested to evaluate for a pars interarticularis defect. Official Disability Guidelines (ODG) state that CT (computed tomography) is indicated to evaluate pars defect. Therefore the request for a CT scan of the lumbar spine is supported. Therefore, the request for CT scan lumbar spine is medically necessary.