

Case Number:	CM14-0126283		
Date Assigned:	08/13/2014	Date of Injury:	04/16/2009
Decision Date:	10/14/2014	UR Denial Date:	08/07/2014
Priority:	Standard	Application Received:	08/08/2014

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 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 injured worker is a 61-year-old female who reported an injury on 04/16/2009. The mechanism of injury was not clearly provided. Her diagnoses included grade 1 spondylosis at the L4-5 level, degenerative disc disease with disc desiccation and herniation at L4-5 and L5-S1, sacroiliitis, bilateral knee pain, and left paracentral disc protrusion with lateral right recess stenosis abutting the left S1 nerve root contributing to radiculopathy/radiculitis. Her past treatments included anti-inflammatory medications, physical therapy, modification of activities, epidural steroid injection on 04/18/2012, and pain management. The injured worker's diagnostic testing including an MRI of the lumbar spine on 06/04/2014, it was noted to have a 4 mm left paracentral protrusion, L5-S1, with annular bulge, moderate facet arthrosis, this was abutting the descending left S1 nerve root with lateral recess stenosis. L4-5 has moderate facet arthrosis with hypertrophy of the ligamentum as well. There were no relevant surgeries noted in the clinical documentation. On 07/03/2014, the injured worker complained of continued low back pain and leg pain with bilateral knee pain. Upon physical examination, she was noted to have limited lumbar spine range of motion secondary to pain. Her flexion was noted at 40% of normal, and her extension was noted at 20% of normal. Her left gastrosoleus is 3/5, and all the other muscle groups were 5/5 proximally and distally. The sensory was noted to be intact to light touch to the bilateral lower extremities. She was noted to have a positive straight leg raise to the left side. Her current pain medications were noted to include high blood pressure medications and pain medications including Percocet, Mobic, and temazepam. The request was for a CT scan of the lumbar spine. The rationale was that the injured worker may be a candidate for a spinous decompression and stabilization such as coflex. The Request for Authorization form was signed and submitted on 07/03/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT Scan of Lumbosacral Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

Decision rationale: The request for CT Scan of Lumbosacral Spine is not medically necessary. The California MTUS/ACOEM Guidelines state lumbar spine x-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least 6 weeks. 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 should be obtained before ordering an imaging study. The injured worker was noted to complain of pain to the back, however, there were no significant neurological deficits on examination. She had an MRI of the lumbar spine on 06/04/2014, and there was no documentation to indicate a new injury occurred since these findings. The documentation did not provide evidence of red flags for serious spinal pathology or new findings upon physical examination. There was no documentation with evidence of failed conservative care to include physical therapy, home exercises, and medications. In the absence of documentation with evidence of failed conservative care and significant objective neurological findings, the request is not supported at this time. Therefore, the request for CT Scan of Lumbosacral Spine is not medically necessary.