

Case Number:	CM14-0150812		
Date Assigned:	09/19/2014	Date of Injury:	05/09/2014
Decision Date:	10/17/2014	UR Denial Date:	09/08/2014
Priority:	Standard	Application Received:	09/16/2014

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, has a subspecialty in Nephrology 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:

This is a 29-year-old female with a 5/9/14 date of injury, when she slipped and fell and injured her lower back. The patient was seen on 8/18/14 with complaints of pain in the low back and pain in the leg, which was mainly on the left site. The patient described her back pain as tingling, achy, sharp, and stabbing and the patient's leg pain was described as numbing, tingling and shooting. The patient underwent 12 PT sessions, which made her pain worse and the patient was taking Norco and Naprosyn. Exam findings revealed diminished left heel and toe walking and heel to toe rising; the patient was not able to tandem without difficulty and she was limping. The seated straight leg-raising test was positive at 80 degrees on the left and 90 degrees on the right. The sensory examination showed "left great toe L5-S1 distribution below the ankle" and the motor strength was 5/5. The deep tendon reflexes were 2+ except the left ankle reflex that was 1+. The diagnosis is lumbar disc displacement. CT scan of the lumbar spine dated 7/14/14 (the radiology report was not available for the review) revealed L5-S1 disc protrusion/herniation. MRI of the lumbar spine dated 9/3/14 revealed: degenerative disc disorder and tear in the posterior annulus of the disc at L5-S1; small posterior disc herniation at L5-S1 which was not displacing underlying nerves; 2-3 mm retrolisthesis of L5-S1; severe combined congenital and degenerative right and left neural foraminal stenosis at L5-S1 at the sites of the right and left L5 nerves, correlated for possible right and left L5 radiculopathy. Treatment to date: PT, hot/cold patches, work restrictions and medications. An adverse determination was received on 9/8/14 given that the patient already had a CT scan of the lumbar spine and that the physical examination did not reveal any red flags for fracture, cancer or infection.

IMR ISSUES, DECISIONS AND RATIONALES

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

x-ray of the lumbar spine (5 views flexion/extension): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic)

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

Decision rationale: CA MTUS states that 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 six weeks. The patient had performed a CT scan of the lumbar spine on 7/14/14 that revealed L5-S1 disc protrusion/herniation. The patient also had an MRI of the lumbar spine performed on 9/3/14 which revealed 2-3 mm retrolisthesis on L5-S1; severe combined congenital and degenerative right and left neural foraminal stenosis at L5-S1 at the sites of the right and left L5 nerves, correlated for possible right and left L5 radiculopathy. In addition, the patient underwent neurosurgical lumbar spine examination, which did not reveal any red flags such as fracture or malignancy. There is no clear rationale with regards to the need for radiographs of the lumbar spine given that the patient's condition did not change and that she underwent CT and MRI of the lumbar spine in the past. Absent a change or progression in neurologic findings, there is no indication for repeat imaging. Therefore, the request for x-ray of the lumbar spine (5 views flexion/extension) was not medically necessary.