

Case Number:	CM15-0007283		
Date Assigned:	01/22/2015	Date of Injury:	03/19/1997
Decision Date:	03/24/2015	UR Denial Date:	01/07/2015
Priority:	Standard	Application Received:	01/13/2015

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: California, Arizona
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 50-year-old male who reported an injury on 03/19/1997. The mechanism of injury was due to a fall. His diagnoses included cervical spondylosis without myelopathy and spinal stenosis of the cervical spine. His past treatment included surgery, spinal cord stimulator, medications. The injured worker had a CT scan of the lumbar spine without contrast on 10/13/2014 revealing postoperative changes of the lumbar spine; sacroiliac change without evidence of hardware malfunction; the L2-L3 indicates spondylolisthesis with L1-2 neural foraminal central canal stenosis; the slight anterolisthesis of L2-3 were unchanged; there is also bilateral facet arthropathy that was unchanged; the fixation screws at the sacroiliac joint level were new; there was also disc osteophyte complex and facet arthropathy contributing to at least mild central canal stenosis and mild neural foraminal narrowing at the L2-3; the broad disc osteophyte complex and facet arthropathy at the L1-2 resulting in a moderate lateral neural foraminal stenosis and mild to moderate central canal stenosis. Pertinent surgical history included an L3-4 laminectomy, partial facetectomy and lateral interbody fusion at L3-4 on 01/21/2013 and spine surgery at the L3-S1 in 1997, 1998, and 2004. On 12/04/2014, the injured worker complained of low back pain with bilateral sciatica. The physical examination of the lumbar spine revealed marked tenderness to palpation over the mid lumbar spine with severe restricted range of motion in all directions. The injured worker also had a bilateral positive straight leg raise in the seated position. The injured worker also had mild weakness in the iliopsoas and quadriceps muscles bilaterally, diminished sensation and normal reflexes. His relevant medications include OxyContin 40 mg, morphine 30 mg, Celebrex 100 mg, Lyrica 150

mg. The treatment plan included an x-ray 7 views of the lumbar spine. The rationale was not provided. A 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:

X-ray 7 views of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines

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

Decision rationale: The request for X-rays 7 views of the lumbar spine is not medically necessary. According to the California MTUS/ACOEM Guidelines, diagnostic studies should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, unless the pain has persisted for at least 6 weeks. In addition, the guidelines indicate that there should be unequivocal objective findings identifying specific nerve compromise on neurologic examination to warrant imaging studies that do respond to treatment before considering surgery an option. The injured worker was indicated to be status post multiple back surgeries. The injured worker also had a recent CT scan on 10/13/2014 that provided clear impressions indicating broad based osteophyte complex and facet arthropathies at the L1-2 and L2-3 levels. However, there was not a clear rationale to indicate medical necessity for a lumbar x-ray. As there was lack of a clear rationale for a lumbar x-ray as a CT has already confirmed specific nerve compromise to correlate neurological examination findings, the request is not supported by evidence based guidelines. As such, the request is not medically necessary.