

Case Number:	CM15-0116036		
Date Assigned:	06/24/2015	Date of Injury:	06/15/2013
Decision Date:	08/14/2015	UR Denial Date:	06/02/2015
Priority:	Standard	Application Received:	06/16/2015

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, 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:

The injured worker is a 39 year old male who sustained an industrial injury on 06/15/2013. Mechanism of injury occurred when he fell 8 feet from scaffolding hitting a wall with his back then falling, seated position, bounding to his bilateral knees hitting his left knee initially. Diagnoses include left knee meniscus tear status post arthroscopy, sprain of the lumbar region and sprain of the knee and leg-right. Treatment to date has included diagnostic studies; status post left knee arthroscopy on 01/28/2014, physical therapy, and chiropractic care, and is participating in a functional restoration program. He is not working. His medications include Celebrex and a Thermacare heat wrap. A physician progress note dated 05/19/2015 documents the injured worker complains of ongoing pain in his back and in his knees, right greater than the left. He has a slow and antalgic gait. On examination of the spine, there is tenderness on palpation to the paravertebral muscles, and tenderness and pain around the area of the sacrum is noted on both sides. The treatment plan includes continuation of the functional rehabilitation program, sacral star pattern Kinesio tape, and gradually increase time with 1/8 inch heel-left for leg length discrepancy, initially painful. Treatment requested is for X-ray of the lumbar spine to include lateral, oblique and posterior anterior.

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 to include lateral, oblique and posterior anterior: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: The CA MTUS/ACOEM Guidelines state that lumbosacral (LS) x-rays are not recommended in patients with low back pain (LBP) in the absence of red flags for serious spinal pathology. Review of the medical records submitted does not establish the evidence of any red flags. The patient has started a functional restoration program with improvement, further demonstrating the lack of need for LS spine imaging. Therefore, this request for LS spine x-rays is deemed not medically necessary.