MAXIMUS Federal Services

Case Number:	CM15-0170512		
Date Assigned:	09/11/2015	Date of Injury:	01/07/2000
Decision Date:	10/08/2015	UR Denial Date:	08/05/2015
Priority:	Standard	Application Received:	08/31/2015

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: 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:

This is a 67-year-old male with a date of injury on 1-7-2000. A review of the medical records indicates that the injured worker is undergoing treatment for chronic low back pain, lumbar disc displacement without myelopathy, snapping hip syndrome, muscle atrophy of the lower extremities and left rotator cuff tear. Medical records (4-22-2015 to 6-29-2015) indicate ongoing left shoulder pain along with limited motion and strength. The injured worker also complained of low back pain with numbness and tingling along the back. He complained of right leg pain and weakness. He described a dull, achy pain that became sharp and burning when walking and standing along the L5 distribution below his right knee. He reported minimal relief from his dorsal column stimulator. The progress report dated 6-17-2015 documents that x-ray of the lumbar spine showed intact L2-S1 cage with moderate to severe degenerative changes at the L1-T12 levels. Per the treating physician (6-29-2015), the employee was temporarily totally disabled. The physical exam (4-22-2015 to 6-29-2015) reveals vertebral spine tenderness along the lower lumbar areas. Range of motion was limited due to pain. He walked with a noticeable limp. Straight leg raise was positive bilaterally. Treatment has included lumbar fusion, physical therapy, and medications (Norco, Cyclobenzaprine and Ambien). The request for authorization dated 7-29-2015 was for spinal nerve stimulator removal, magnetic resonance imaging (MRI) of the lumbar spine and computed tomography of the lumbar spine. The original Utilization Review (UR) (8-5-2015) non-certified a request for computed tomography of the lumbar spine. Utilization Review certified requests for magnetic resonance imaging (MRI) of the lumbar spine and removal of spinal cord stimulator.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT of Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: The ACOEM chapter on low back complaints and special diagnostic studies states: 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 and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures). Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false positive test results) because of the possibility of identifying a finding that was present before symptoms began and therefore has no temporal association with the symptoms. Techniques vary in their abilities to define abnormalities (Table 12-7). Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Because the overall false-positive rate is 30% for imaging studies in patients over age 30 who do not have symptoms, the risk of diagnostic confusion is great. There is no recorded presence of emerging red flags on the physical exam. There is evidence of nerve compromise on physical exam but there is not mention of consideration for surgery or complete failure of conservative therapy. For these reasons, criteria for imaging as defined above per the ACOEM have not been met. Therefore the request is not medically necessary.