MAXIMUS Federal Services

Case Number:	CM15-0095327		
Date Assigned:	05/21/2015	Date of Injury:	01/20/2008
Decision Date:	06/24/2015	UR Denial Date:	04/29/2015
Priority:	Standard	Application Received:	05/18/2015

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: Arizona, California
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 53-year-old male, with a reported date of injury of 01/20/2009. The diagnoses include neck pain and status post lumbar spinal fusion. Treatments to date have included L3 to sacral fusion, a DEXA scan, computerized tomography (CT) scans of the lumbar spine, x-rays of the lumbar spine, and MRI of the lumbar spine, oral medications, and x-rays of the cervical spine. The post-operative report dated 04/20/2015 indicates that the injured worker was getting significantly worse, and he had begun to drag his right lower extremity. The objective findings include mild weakness of the iliopsoas on the left and the extensor hallucis longus on the left; and negative bilateral straight leg raise test. X-rays of the lumbar spine were taken at the appointment, which showed segmental physiologic instability and neural foraminal stenosis. The treating physician recommended a new MRI of the lumbar spine, as his symptoms had progressed since the last MRI of the lumbar spine in 11/2014, and because there were multiple abnormalities seen on the x-rays recently taking. The treating physician stated that the injured worker needed to undergo a CT scan of the lumbar spine to evaluate for possible pseudoarthrosis at L3-4 where there was increased uptake in the endplates of the L3-4 disk space on the right side. The treating physician requested an MRI of the lumbar spine without contrast and a computerized tomography (CT) scan of the lumbar spine without contrast.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the lumbar spine without contrast: 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): 309.

Decision rationale: According to the ACOEM guidelines, an MRI of the lumbar spine is recommended for red flag symptoms such as cauda equina, tumor, infection, or uncertain neurological diagnoses not determined or equivocal on physical exam. There were no red flag symptoms. There was no plan for surgery. The claimant had a SPECT CT bone scan showing reactive changes commonly seen at site of surgery and degenerative changes. There is no red flag pathology indicating need for another MRI. The request for an MRI of the lumbar spine is not medically necessary.

CT Scan of the lumbar spine without contrast: 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): 309.

Decision rationale: According to the ACOEM guidelines, a CT of the lumbar spine is recommended for red flag symptoms such as cauda equina, tumor, infection, or uncertain neurological diagnoses not determined or equivocal on physical exam. There were no red flag symptoms. There was no plan for surgery. The claimant had a SPECT CT bone scan showing reactive changes commonly seen at site of surgery and degenerative changes. There is no red flag pathology indicating need for another CT. The request for a CT of the lumbar spine is not medically necessary.