Case Number:	CM14-0105685		
Date Assigned:	09/16/2014	**Date of Injury:**	07/30/1998
Decision Date:	12/02/2014	**UR Denial Date:**	06/13/2014
Priority:	Standard	**Application Received:**	07/08/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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:

The patient is a 55 year old female who had a work injury dated 7/30/98. The diagnoses include degenerative disc disease, lumbar spondylosis; lumbar spondylolisthesis. Under consideration are requests for CT lumbar spine without dye. An MRI of the lumbar spine performed on 11/26/13 revealed extensive degenerative bone, disk and joint changes noted throughout the lumbar spine with associated spinal stenosis, foraminal narrowing and alignment abnormalities.A single-photon emission computerized tomography (SPECT) bone scan/whole body bone scan performed on 05/30/14 revealed the following: 1) The most intense uptake in the lumbar spine appears to be associated with bilateral facet arthritis at L4-5 and L5-Sl; 2) No evidence of a recent spinal compression fracture and 3) Other arthritic changes are evident (shoulders, right knee) on the whole body images, but there is no evidence of a process such as metastatic bone disease. There is a progress note dated 6/6/14 that states that the patient presented with low back pain that radiated to the back of her thighs then into her legs and feet, right greater than left. She states that she has difficulty ambulating due to pain; cramps in her feet, calves and lower extremity weakness, right greater than left. On examination there was decreased and painful flexion, extension and lateral bending at waist; decreased right lower extremity sensation and antalgic gait. The patient was diagnosed with spondylolisthesis of lumbar region and lumbar stenosis. The treatment plan included flexion/extension rays of the lumbar spineto evaluate mobile spondylolisthesis at L3-4 and L5-S l and a CT scan without contrast for the lumbar spine to evaluate bony structure.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT lumbar spine without dye: Upheld

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

Decision rationale: CT lumbar spine without dye is not medically necessary per the MTUS and the ODG guidelines. The MTUS ACOEM guidelines state that 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, computer tomography [CT] for bony structures) .The ODG states that a lumbar CT is not necessary unless there is lumbar trauma, myelopathy, a pars defect not identified on x rays, or status post fusion if x-rays do not confirm a successful fusion. The documentation does not indicate new trauma or physical exam evidence of myelopathy or a possible pars defect on x-rays. The patient has already had 2 MRIs, a SPECT scan, and authorization for flexion/extension x-rays. There are no supporting physical exam findings which necessitate the addition of lumbar CT scanning. The request for CT of the lumbar spine without dye is not medically necessary.