

<b>Case Number:</b>	CM14-0043108		
<b>Date Assigned:</b>	06/30/2014	<b>Date of Injury:</b>	01/13/2011
<b>Decision Date:</b>	08/21/2014	<b>UR Denial Date:</b>	03/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/10/2014

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 65-year-old male who has submitted a claim for Status Post Decompression Fusion at L4-5/L5-S1 and Degeneration of Lumbosacral Intervertebral Disc associated with an industrial injury date of January 13, 2011. Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of low back and left leg pain, worsened with gardening activities. On physical examination, there was mild tenderness across the lumbosacral region. Range of motion was improving. No sensorimotor deficits were noted and reflexes were normal. X-ray of the lumbar spine dated March 11, 2014 revealed post decompression/fusion at L4-5 and L5-S1 (solid appearing fusion); and some lucency around the L4 screws, which was similar to his previous x-ray. CT scan of the lumbar spine dated May 14, 2014 revealed severe discogenic and facet arthropathy, resulting in multilevel neural foraminal stenosis most prominent at the operative levels, as well as at the L3-4 level, left greater than right; post-operative changes; and no definite acute osseous abnormality seen. Treatment to date has included medications, home exercise program, laminectomy (2011), and L4-5 and L5-S1 fusion (2013). Utilization review from March 19, 2014 denied the request for intrathecal contrast computed tomography of the lumbar spine because there were no subjective issues of pain or functional issues or objective findings on examination that would suggest issues related to lumbar spine fusion.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Intrathecal contrast computed tomography of the lumbar spine.: 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): 303-304.

**Decision rationale:** According to pages 303-304 of the ACOEM Practice Guidelines referenced by CA MTUS, 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 neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. In this case, CT scan was requested to assess the possibility of pseudoarthrosis. The requesting physician further stated that pseudoarthrosis meant that despite what the plain film x-rays showed, there may have been movement causing the lucency around the screws, and movement meant that the fusion may not have been completely solid. However, an x-ray of the lumbar spine dated March 11, 2014 already revealed findings of a solid appearing fusion. The x-ray further showed that the lucency around the L4 screws was already evident on the patient's previous x-rays. Thus, plain radiographs have already revealed satisfactory findings regarding the patient's fusion status. Furthermore, there were no unequivocal objective findings of nerve compromise on physical examination and there was no discussion regarding failure of response to present treatment. There is no clear indication for a CT scan at this time. Therefore, the request for intrathecal contrast computed tomography of the lumbar spine is not medically necessary.