

<b>Case Number:</b>	CM14-0060098		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	03/17/2009
<b>Decision Date:</b>	07/21/2014	<b>UR Denial Date:</b>	02/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/13/2014

### 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 Occupational Medicine and is licensed to practice in California. 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 claimant was injured on 03/17/09. A computerized tomography scan of the lumbar spine has been ordered and is under review. She saw [REDACTED] on 09/30/13 and complained of chronic low back pain that radiated to her left leg. She was limping and it was worse over the past 2 days. She was taking gabapentin, ibuprofen, and tramadol. Physical examination of the low back revealed no neurologic deficits. Her gait was within normal limits. Sensation was intact. There was no spinal tenderness, subluxation or reduced range of motion. She was diagnosed with a lumbar disc and neurogenic bladder. She was expected to improve from a flareup of pain. She was taking medications and was given additional medication. She was seen on 11/25/13 for chronic lumbar pain and urinary incontinence. She has a lumbar disc herniation. She still had some bladder leakage. She had difficulty initiating urination. Her physical findings were the same. She was going to need constant permanent medical care. On 01/28/14, she was seen again and had persistent pain in the low back radiating down the left leg to the big toe. She had decreased sensation diffusely in the right leg all the way to the groin area. X-rays showed a solid fusion at L5-S1 and implants were in place. The foramen appeared to be a little tight. A CT scan was recommended to rule out persistent foraminal stenosis at the L5-S1 levels. EMG/nerve conduction studies were also recommended by [REDACTED].

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CT Scan of lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**Decision rationale:** The history and documentation do not objectively support the request for a computerized tomography scan (CT) of the lumbar spine. The California Medical Treatment Utilization Schedule (MTUS) American College of Occupational and Environmental Medicine (ACOEM) Guidelines state "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). Electromyography (EMG), including H reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. Discography is not recommended for assessing patients with acute low back symptoms. Table 12-7 provides a general comparison of the abilities of different techniques to identify physiologic insult and define anatomic defects [and indicates that CT scan can be recommended for the evaluation of a disc protrusion, cauda equina syndrome, spinal stenosis and post laminectomy syndrome.] An imaging study may be appropriate for a patient whose limitations due to consistent symptoms have persisted for one month or more to further evaluate the possibility of potentially serious pathology, such as a tumor. 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." In this case, it is not entirely clear why this type of imaging study is being recommended. The claimant has diffuse sensory deficits and no specific focal findings. There is no indication that surgery is being considered. Electrodiagnostic studies were also recommended but no report was received. The medical necessity of this request has not been clearly demonstrated.