

<b>Case Number:</b>	CM14-0079263		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	07/26/2010
<b>Decision Date:</b>	08/28/2014	<b>UR Denial Date:</b>	05/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/29/2014

### 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 Sports Medicine, and is licensed to practice in Georgia. 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 42 year-old male who was injured on 07/26/2010. The mechanism of injury has not been documented. There is no prior treatment history available for review. Progress report dated 08/05/2013, citing outside records, notes a previous x-ray report showed pedicle screw instrumentation L4-S1. Per a progress report dated 05/12/2014, x-rays of the lumbar spine were performed on this date and demonstrated possible movement at the L4-L5 level. No obvious sign of fusion mass and possible L5-S1 screw fractures. Orthopedic evaluation dated 05/12/2014 stated the patient presented for follow up evaluation. He reported back pain and described it as constant and radiating to the left leg and buttock. He reported he had been taking Soma and Percocet as directed. On exam, he had normal heel-toe gait. Range of motion of the lumbar spine was 85% with no focal neurological deficit. He was diagnosed status post L4 to S1 fusion, on 01/14/2011. A CT scan of the lumbar spine was recommended to determine if there is solid fusion and about the nature of the screws at L5-S1. His medications were refilled. Prior utilization review dated 05/19/2014 stated the request for a CT of the lumbar spine without dye had been denied as there was inadequate clinical submitted to support the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CT lumbar spine w/o dye:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Williams AL, Gornet MF, and Burkus JK. CT Evaluation of Lumbar Interbody Fusion: Current Concepts. American Journal of Neuroradiology. 2005;26:2057-2066. Available a

**Decision rationale:** The American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, in the Chapter on Low Back Complaints 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. It further notes that when the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. In this patient's case, however, there is radiographic evidence which suggests possible failure of fusion hardware. As noted in the article cited above from the American Journal of Neuroradiology, computer tomography (CT) has developed into the preferred method of assessing interbody fusion and can often identify failure of device fixation and nonunion. Based on the medical evidence and the clinical documentation provided, the request for a lumbar CT without contrast is medically necessary.