

<b>Case Number:</b>	CM15-0003870		
<b>Date Assigned:</b>	01/14/2015	<b>Date of Injury:</b>	09/05/2012
<b>Decision Date:</b>	03/10/2015	<b>UR Denial Date:</b>	12/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/08/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 43 year old male who sustained a work related injury September 5, 2012. Past surgical history includes a bilateral L4-L5 transforaminal lumbar Interbody fusion with post-lateral arthrodesis at L4 to S1 using pedicle screw/rod fixation, local bone graft and laparoscopic open ventral hernia repair with mesh July, 2014. According to a treating physician's report dated December 2, 2014, the injured worker presented with complaints of lower back and bilateral lower extremity pain. He was noted to have completed 24 session of physical therapy since surgery and additional sessions were not authorized, currently taking Norco 3-4 times per week. Physical examination reveals height 5 feet 7 inches 220 pounds. The gait is slow but strong heel toe walking while holding his hands for balance. Lumbar spine range of motion is restricted with flexion to 25 degrees and extension limited to 5 degrees with pain. Straight leg raising test is negative and Faber's and Trendelenburg's test are negative. Motor and sensory examination is normal. Diagnosis is documented as low back pain. Treatment includes; discussion and education of medications and side effects, and request for MRI(magnetic resonance imaging) of the lumbar spine and CT (computed tomography) Scan L3 to S1 to rule out non-union of L4-S1 arthrodesis. According to utilization review dated December 11, 2014, the request for CT (computed tomography) Scan L3-S1 Lumbar Spine is not certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CT scan L3-S1 lumbar spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Indications for imaging

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Chapter 12- Low Back Complaints, Imaging, pages 303-304.

**Decision rationale:** Request for updated CT scan. Exam showed tenderness and decreased range, but with intact neurological exam in motor strength, sensation, and reflexes without remarkable provocative testing. The patient is without physiologic evidence of tissue insult, neurological compromise, or red-flag findings to support imaging request. Per ACOEM Treatment Guidelines states Criteria for ordering imaging studies include Emergence of a red flag; Physiologic evidence of tissue insult or neurologic dysfunction; Failure to progress in a strengthening program intended to avoid surgery; Clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination and electrodiagnostic studies. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist; however, review of submitted medical reports have not adequately demonstrated the indication for CT scan of the Lumbar spine nor document any specific acute clinical findings to support this imaging study as the patient has intact motor strength, DTRs, and sensation throughout bilateral lower extremities. When the neurologic examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. The CT scan L3-S1 lumbar spine is not medically necessary and appropriate.