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| <b>Case Number:</b>   | CM15-0160557 |                              |            |
| <b>Date Assigned:</b> | 08/26/2015   | <b>Date of Injury:</b>       | 08/13/2013 |
| <b>Decision Date:</b> | 09/30/2015   | <b>UR Denial Date:</b>       | 08/04/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 08/17/2015 |

### 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: Texas, California  
 Certification(s)/Specialty: Family Practice

### 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 52 year old female who sustained an industrial injury on 8-13-2013. She has reported lower back pain and has been diagnosed with spinal stenosis lumbar without neurogenic claudication and acquired spondylolisthesis. Treatment has included medical imaging, physical therapy, acupuncture, and medication. There was tenderness in the paravertebral muscles from L4 to S1. There were marked paraspinal spasms bilaterally. Range of motion was limited because of pain with marked limitation of flexion and extension. The treatment plan included an MRI of the lumbar spine. The treatment request included retrospective CT scan of the lumbar spine without contrast. The patient sustained the injury when she was lifting a heavy object. The medication list include Motrin and Neurontin. The patient has had MRI of the lumbar spine on 11/8/13 that revealed degenerative changes, central canal stenosis, and disc protrusion; CT scan of lumbar spine on 4/9/15 that revealed facet arthropathy. Any surgical or procedure note related to this injury was not specified in the records provided. The patient had received an unspecified number of PT visits for this injury. Per the note dated 4/8/15 the patient had complaints of low back pain. The medication list include Tramadol, Gabapentin, Nabumatone, and Cyclobenzaprine. Per the note dated 12/17/14 the patient had complaints of low back pain at 8/10 with tingling sensation. Physical examination of the lumbar spine revealed limited range of motion, tenderness on palpation, normal strength, sensation and reflexes. The patient has had normal gait and negative SLR on 2/4/15.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro CT Scan of Lumbar Spine without Contrast: Upheld**

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

**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) CT (computed tomography) Low Back (updated 07/17/15).

**Decision rationale:** Request: Retro CT Scan of Lumbar Spine without Contrast. Per the ACOEM low back guidelines cited below "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)." In addition per the ODG guidelines lumbar CT is "Not recommended except for indications lumbar spine trauma, with neurological deficit, with seat belt fracture; myelopathy traumatic, infectious disease patient; evaluate pars not identified by plain X-rays." The patient has had MRI of the lumbar spine on 11/8/13 that revealed degenerative changes, central canal stenosis, and disc protrusion; any significant changes in objective physical examination findings since the last imaging that would require a repeat study were not specified in the records provided. Repeat studies are reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neuro-compression, recurrent disc herniation). Any of these indications for lumbar spine CT scan without contrast were not specified in the records provided. Per the note dated 12/17/14 physical examination of the lumbar spine revealed normal strength, sensation and reflexes. The patient has had normal gait and negative SLR on 2/4/15. Any significant functional deficits on physical examination that would require CT Scan of Lumbar Spine was not specified in the records provided patient did not have any progressive neurological deficits that are specified in the records provided. Findings suggestive of suspicious for tumor, infection, fracture, neurocompression, or other red flags were not specified in the records provided. The patient had received an unspecified number of PT visits for this injury. Prior PT visits notes were not specified in the records provided. The records submitted contain no accompanying current PT evaluation for this patient. The medical necessity of the request for Retro CT Scan of Lumbar Spine without Contrast is not fully established in this patient.