

<b>Case Number:</b>	CM15-0160939		
<b>Date Assigned:</b>	08/27/2015	<b>Date of Injury:</b>	10/01/2014
<b>Decision Date:</b>	10/02/2015	<b>UR Denial Date:</b>	07/30/2015
<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: 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 57 year old female who sustained an industrial injury on October 01, 2014. The worker is employed as a medical assistant. A recent primary treating office visit dated July 16, 2015 reported subjective complaint of constant low back pain radiating to the bilateral lower extremities with numbness and tingling. The following diagnoses were applied: lumbar disc protrusion; lumbar spinal stenosis; lumbar radiculopathy, and lumbar facet syndrome. The plan of care noted prescribing the following: Norco 10mg 325mg, Tramadol, Colace, Xanax, Terocin patches, and Medrol. She also utilizes two topical compound creams. On July 01, 2015 she was prescribed to undergo a computerized tomography scan of lumbar spine to evaluate fusion at L4-5. Subjective complaints at this follow up July 02, 2015 noted low back pain. She is diagnosed with the following: chronic low back pain; left paracentral herniation at L5-s1; grade I-II degenerative anterolisthesis at L4-5 with significant disc collapse and severe stenosis; lumbar radiculopathy and tobacco abuse. She was placed on temporary total disability.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CT lumbar spine:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), CT (computed tomography).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back Chapter under CT scans.

**Decision rationale:** Based on the 7/1/15 progress report provided by the treating physician, this patient presents with constant low back pain radiating to the back/sides of bilateral legs with numbness/tingling/burning. The treater has asked for CT LUMBAR SPINE but the requesting progress report is not included in the provided documentation. The patient's diagnoses per request for authorization form dated The request for authorization was not included in provided reports. The patient is s/p multiple lumbar MRIs, an ankle surgery, epidural steroid injection 10 years ago with unspecified benefit, and a course of physical therapy 11-12 years ago after a fall at work with a full recovery per 7/1/15 report. The patient's current medications include Norco, Tramadol, Xanax, and Motrin per 7/1/15 report. The patient had 2 recent epidural steroid injections, the first one with temporary relief and the second one on 3/20/15 which was not helpful per 6/16/15 report. The patient is unable to sit for more than 10 minutes per 6/16/15 report. The patient's work status is temporarily totally disabled, and has been off-work since 10/10/14 per 7/1/15 report. ODG guidelines, Low back Chapter under CT scans: Not recommended except for indications below for CT. Magnetic resonance imaging has largely replaced computed tomography scanning in the noninvasive evaluation of patients with painful myelopathy because of superior soft tissue resolution and multiplanar capability. Indications for imaging: Thoracic spine trauma: equivocal or positive plain films, no neurological deficit- Thoracic spine trauma: with neurological deficit- Lumbar spine trauma: trauma, neurological deficit- Lumbar spine trauma: seat belt -chance- fracture - Myelopathy -neurological deficit related to the spinal cord-, traumatic- Myelopathy, infectious disease patient- Evaluate pars defect not identified on plain x-rays- Evaluate successful fusion if plain x-rays do not confirm fusion. Although the requesting progress report was not included, treater stated that CT scan of the lumbar spine was ordered on 7/1/15 "to see if there was an autofusion at L4-5" per 7/9/15 report. The patient was recommended to undergo a posterior lumbar fusion surgery at L4-5 per 7/9/15 report. ODG does not recommend CT scan of the lumbar spine unless there is lumbar spine trauma with neurologic deficit, or seat belt trauma with chance of fracture. In addition, a CT would be also indicated to evaluate fusion. This patient has had multiple imaging studies including an updated lumbar MRI on 3/18/15 which showed "a L4-5 central canal and bilateral foraminal stenosis due to Grade II spondylolisthesis. At L5 endplate the subarticular gutters were obliterated[obliterated] from posterior; L5-S1 showed narrowed facets, irregular right facet and a 5mm left sided disc herniation causing left lateral recess stenosis. There was loss of disc space signal at L1-2 and L2-3." The original MRI report was not included in provided documentation. A lumbar X-ray, of unspecified date, in 5/28/15 progress report showed "5 lumbar vertebrae. Pedicle shadows are intact. Significant facet arthropathy noted at L4-5. Lateral view shows grade 2 degenerative spondylolisthesis at L4-5 with complete disc collapse."In this case, there is a grade II spondylolisthesis at L4-5 and the treater is concerned about potential autofusion at this level for which a CT scan is asked for. The request appears reasonable. The request IS medically necessary.