

<b>Case Number:</b>	CM15-0087352		
<b>Date Assigned:</b>	05/11/2015	<b>Date of Injury:</b>	08/18/1999
<b>Decision Date:</b>	06/10/2015	<b>UR Denial Date:</b>	04/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/06/2015

### 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: New Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 49-year-old male, who sustained an industrial injury on August 18, 1999. He reported severe low back pain. The injured worker was diagnosed as having chronic severe low back pain status post lumbar fusion, severe neuropathic pain, severe myofascial pain/spasm, opioid dependency with efficacy but tolerance, depression secondary to pain, severe nausea with opioid use, poor sleep hygiene, hypogonadism secondary to back surgery and analgesic side effects and IT pump placement with adjustments. Treatment to date has included radiographic imaging, diagnostic studies, surgical intervention of the lumbar spine, intrathecal pump placement, conservative care, medications and work restrictions. Currently, the injured worker complains of severe low back pain radiating down bilateral lower extremities with muscle spasms, restless sleep and difficult ambulation. The injured worker reported an industrial injury in 1999, resulting in the above noted pain. He was treated conservatively and surgically without complete resolution of the pain. He reported requiring the use of medications to remain functional. He reported difficulty with ambulation and activities of daily living. Evaluation on May 7, 2015, revealed continued pain with associated symptoms. The physician noted obvious pain upon assessment and reported the injured worker frequently changed positions during the examination. Computed tomography (CT) scan of the lumbar spine was requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **CT scan of the lumbar spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment for Workers' Compensation (ODG-TWC) Low Back Procedure Summary Online Version last updated 04/15/2015.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation CT (computed tomography) <http://www.odg-twc.com/index.html>.

**Decision rationale:** According to ODG guidelines, Computed Tomography: Not recommended except for indications below for CT. (Slebus, 1988) (Bigos, 1999) (ACR, 2000) (Airaksinen, 2006) (Chou, 2007) 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. (Seidenwurm, 2000) The new ACP/APS guideline as compared to the old AHCPR guideline is more forceful about the need to avoid specialized diagnostic imaging such as computed tomography (CT) without a clear rationale for doing so. (Shekelle, 2008) A new meta-analysis of randomized trials finds no benefit to routine lumbar imaging (radiography, MRI, or CT) for low back pain without indications of serious underlying conditions, and recommends that clinicians should refrain from routine, immediate lumbar imaging in these patients. (Chou-Lancet, 2009) Primary care physicians are making a significant amount of inappropriate referrals for CT and MRI, according to new research published in the Journal of the American College of Radiology. There were high rates of inappropriate examinations for spinal CTs (53%), and for spinal MRIs (35%), including lumbar spine MRI for acute back pain without conservative therapy. (Lehnert, 2010) For suspected spine trauma (ie, fractures, lumbar or cervical), thin-section CT examination with multiplanar reconstructed images may be recommended. Image software postprocessing capabilities of CT, including multiplanar reconstructions and 3-dimensional display (3D), further enhance the value of CT imaging for reconstructive trauma surgeons. (Daffner, 2009) Indications for imaging Computed tomography: 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. (Laasonen, 1989) There is no evidence in this case of recent lumbar trauma or a neurological deficit including signs of myelopathy or spine infection. Therefore, the request for CT scan of the lumbar spine is not medically necessary.