

<b>Case Number:</b>	CM14-0112690		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	09/16/2007
<b>Decision Date:</b>	09/26/2014	<b>UR Denial Date:</b>	07/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/18/2014

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in California. 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:

According to the records made available for review, this is a 41-year-old female with a 9/16/07 date of injury, and status post L4-5 anterior interbody fusion 6/28/10. At the time (6/18/14) of request for authorization for CT scan of the lumbar spine, there is documentation of subjective complaints for multiple body parts pain complaints, continued left hip pain that has been gradually worsening since injection in February 2014. The objective findings include antalgic gait, tenderness to palpation over left hip greater trochanteric bursa, range of motion of left hip decreased by 20% with flexion, 30% with extension and 40% with reduction, and pain with internal and external rotation of left hip. Imaging findings are a lumbar Spine CT (6/27/11) which revealed material within disc space at L4-5, likely represents a bone graft which is fused to the superior endplate of L5; a spate narrow column of bony fusion is seen at the posterior aspect of the disc space as well; report not available for review. Current diagnoses a lumbar disc displacement without myelopathy, neck pain, pain in joint shoulder, and pain in limb. Treatment to date includes medications, including ongoing treatment with Fentanyl patch, Lidocaine ointment, Protonix, Diclofenac cream, and Bupropion, physical therapy, activity modifications, and surgery. There is no documentation of a diagnosis/condition with supportive subjective/objective findings for which a repeat study is indicated.

### 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:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Treatment Index, 12th edition (web), 2014, Low Back- MRI, Radiography (x-rays), Lumbar CT; Knee and Leg, Doppler ultrasound.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Minnesota Rules, 5221.6100 Parameters for Medical Imaging.

**Decision rationale:** MTUS reference to ACOEM Guidelines identifies documentation of red flag diagnoses where plain film radiographs are negative; objective findings that identify specific nerve compromise on the neurologic examination, failure of conservative treatment, and who are considered for surgery, as criteria necessary to support the medical necessity of a CT. Official Disability Guidelines (ODG) identifies documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (such as: To diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings) as criteria necessary to support the medical necessity of a repeat MRI. Within the medical information available for review, there is documentation of diagnoses of lumbar disc displacement without myelopathy, neck pain, pain in joint shoulder, and pain in limb. In addition, there is documentation of a previous lumbar spine CT on 6/27/11. However, given no documentation of subjective and objective findings regarding the lumbar spine, there is no documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (to diagnose a change in the patient's condition marked by new or altered physical findings). Therefore, based on guidelines and a review of the evidence, the request for CT scan of the lumbar spine is not medically necessary.