

<b>Case Number:</b>	CM15-0171969		
<b>Date Assigned:</b>	09/14/2015	<b>Date of Injury:</b>	05/20/2000
<b>Decision Date:</b>	10/13/2015	<b>UR Denial Date:</b>	08/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/01/2015

### 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: 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 41 year old female who sustained an industrial injury May 20, 2000. Past history included discectomy, L5-S1 2009, asthma, and depression. According to a treating physician's progress report, dated August 13, 2015, the injured worker presented with reports of significant relief with 2 sessions of chiropractic and acupuncture treatment. She reported her pain level reduced from 7 out of 10 to 3 out of 10, lasting approximately 2-3 days for each service. She was able to reduce her Percocet to 3 maximum per day. She is swimming one hour twice weekly and walking approximately 20-30 minutes a day in conjunction with the acupuncture and chiropractic therapy. She would like to return to physical therapy as she has not had sessions since 2009. She does complain of chronic low back pain. She has had several lumbar epidural injections, the last 5 months ago with a 5 month pain relief of greater than 70%. Physical examination revealed; 5' 1" and 190 pounds; gait and station slow with right antalgic gait and unable to heel toe walk; right L4-S1 diminished sensation to pain and temperature; lumbar spine flexion 80 degrees, extension 20 degrees; bilateral facet loading test positive; straight leg raise positive on the right. Diagnoses are lumbar degenerative disc disease; lumbar facet arthropathy; post-laminectomy syndrome; sciatica. Treatment plan included continued chiropractic therapy and acupuncture, physical therapy, refilled medication, and at issue, a request for authorization for CT of the lumbar spine with and without contrast. According to utilization review dated August 24, 2015, the request for CT of the lumbar spine with and without contrast between August 13, 2015 and October 17, 2015 is non-certified.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **1 CT of the lumbar spine with and without contrast: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar & Thoracic (Acute & Chronic), CT (computed tomography).

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Diagnostic Criteria, Physical Examination, Special Studies, Summary. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Low Back Section: CT Tomography.

**Decision rationale:** The MTUS/ACOEM Guidelines comment on the evaluation and management of patients with low back complaints. These guidelines include recommendations for the use of imaging studies to include MRI and CT imaging. In the evaluation of patients with low back complaints, it is expected that the clinician will assess and document the presence of any red flag signs or symptoms that suggest the presence of a potentially serious underlying condition. The presence of these red flag signs or symptoms typically lead to the request for an imaging study such as a CT scan. In this case, there is insufficient documentation to support the need for a CT image of the lumbar spine. Specifically, there is no documentation of any of the above cited red flag signs or symptoms. The available records do not provide evidence of a significant change in symptoms or physical examination findings. The patient had a prior MRI of the lumbar spine; however, the results of this MRI are not included in the medical records for review. The rationale provided in the records to justify a CT scan does not include evidence of emerging red flag signs or symptoms or a change in physical examination findings. Without this level of documentation, there is insufficient grounds to pursue a CT scan of the lumbar spine. The Official Disability Guidelines also comment on the use of CT imaging studies for low back complaints. These guidelines state the following: 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. Again, in this case, there is no documentation in the medical records that the patient meets any of the above criteria in support of CT imaging. In summary, the medical records provide insufficient information based on the MTUS/ACOEM Guidelines and the Official Disability Guidelines, to justify a CT of the lumbar spine with and without contrast. At this time the test is not medically necessary.