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| Case Number: | CM13-0017904 | | |
| Date Assigned: | 10/11/2013 | Date of Injury: | 11/10/2006 |
| Decision Date: | 05/02/2014 | UR Denial Date: | 08/08/2013 |
| Priority: | Standard | Application Received: | 08/28/2013 |

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 52-year-old female with a 11/10/06 date of injury and status post lumbar decompression and fusion at L4-L5 and L5-S1 on 12/13/12. At the time (8/7/13) of the decision for CT myelogram, there is documentation of subjective (low back pain and increasing pain in the bilateral lower extremities) and objective (spasm and tenderness in the lumbar spine) findings. The imaging findings (MRI of the lumbar spine on 10/11/12) report revealed postsurgical changes at L4-L5, multilevel degenerative disc disease, moderate bilateral foraminal stenosis at L5-S1 and L4-L5, and evidence of a 3 mm focal disc protrusion at L5-S1 with a small zone of high signal suggesting a small radial tear. The current diagnoses include spinal stenosis, lumbar region, without neurogenic claudication; degeneration of lumbar or lumbosacral intervertebral disc; and lumbosacral spondylosis without myelopath. The treatment to date includes lumbar decompression and fusion at L4-L5 and L5-S1. In addition, the 7/10/13 medical report plan identifies CT myelogram to rule out any issues with the screws or any nerve root compression. There is no documentation of preoperative planning and MRI not available; and MRI is contraindicated (e.g. metallic foreign body), or inconclusive.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT MYELOGRAM: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310. Decision based on Non-MTUS Citation ODG

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Decision rationale: The MTUS/ACOEM Guidelines identify documentation of preoperative planning if the MRI is not available, as criteria necessary to support the medical necessity of myelography. The Official Disability Guidelines identify that myelography is recommended when an MRI is unavailable, contraindicated, such as a metallic foreign body, or inconclusive. Within the medical information available for review, there is documentation of the diagnoses of spinal stenosis, lumbar region, without neurogenic claudication; degeneration of lumbar or lumbosacral intervertebral disc; and lumbosacral spondylosis without myelopathy. In addition, given documentation of MRI of the lumbar spine identifying postsurgical changes at L4-L5, multilevel degenerative disc disease, moderate bilateral foraminal stenosis at L5-S1 and L4-L5, and evidence of a 3 mm focal disc protrusion at L5-S1, with a small zone of high signal suggesting a small radial tear. There is no documentation of preoperative planning, or an MRI that is not available. The medical records do not show evidence that an MRI is contraindicated, or inconclusive. Therefore, based on guidelines and a review of the evidence, the request for CT myelogram is not medically necessary.