

<b>Case Number:</b>	CM15-0237444		
<b>Date Assigned:</b>	12/14/2015	<b>Date of Injury:</b>	02/27/2006
<b>Decision Date:</b>	01/20/2016	<b>UR Denial Date:</b>	11/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/04/2015

### 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 48 year old male, who sustained an industrial injury on 2-27-06. The injured worker was diagnosed as having lumbar dis herniation associated with facet joint hypertrophy; herniated disc L4-5 and L5-S1 with central and foraminal stenosis; left lower extremity radiculopathy; reactionary depression-anxiety; uncontrolled severe hypertension; 3-level positive provocative discography; status post bypass graft x3 vessels (11-20-12); medication induced gastritis; right lateral epicondylitis. Treatment to date has included physical therapy; status post spinal cord stimulator and intrathecal pump; medications. Diagnostics studies included MRI lumbar spine (4-9-15). Currently, the PR-2 notes dated 10-2-15 indicated the injured worker was last seen in the office on 9-8-15. He continues having pain in the lower back radiating down to his right lower extremity. It is aggravated by any type of bending, twisting or turning. The provider notes, "the patient reports significant limitations to both mobility and activity tolerance with his pain going as high as 9 out of 10 in intensity but on his current medical regimen it is decreased to 7 out of 10. He has undergone extensive conservative management but remains symptomatic. He did undergo a trial of lumbar spinal cord stimulator 10-21-10 and reported a good 50-60% pain relief but unfortunately was unable to tolerate the paresthesia effect. He did undergo a trial of intrathecal morphine pump 8-7-14, which provided excellent pain relief. He was scheduled for a permanent implantation of the intrathecal device on 11-10-14 but was cancelled due to elevated blood pressure (190-123mm Hg. He was re-scheduled 1-29-15 but was cancelled since his INR was elevated at 2.2 and remains on Coumadin 10mg twice a day. We have not been able to reschedule his pump implant as he also

had a ruptured appendix March 2015 and underwent exploratory surgery." The provider continues with: The patient does have multilevel disc disease including a positive discogram at L4-5 greater than L3-4 and L5-S1. He was seen by an orthopedic spine specialist and internist. He is cleared to proceed with placement of the intrathecal pump with instructions to hold Coumadin for one week. The injured worker is now requesting a second opinion for consideration of surgical intervention. He is stable of some pain relief of 28-30% and has been taking high doses of opioid medication including OxyContin, Roxicodone and Norco and Neurotin, Prilosec. The provider reviews diagnostic studies including a MRI of the lumbar spine done 4-9-15. It revealed 4-5.4mm diffuse disc herniations most significant at L4-5 with moderate central and bilateral lateral recess stenosis with bilateral neural foraminal stenosis. The provider's treatment plan includes a request for a "CT myelogram as previous MIR has been denied and we are looking for foraminal as well as central stenosis to check the patient's increased radicular neurogenic claudication symptoms." A Request for Authorization is dated 12-4-15. A Utilization Review letter is dated 11-5-15 and non-certification for CT myelogram lumbar spine. A request for authorization has been received for CT myelogram lumbar spine.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **CT myelogram lumbar spine: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic).

**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 Computed Tomography, Low Back chapter, under lumbar myelogram.

**Decision rationale:** The 48 year old patient complains of ongoing low back pain radiating to the right lower extremity, rated at 9/10 without medications and 7/10, as per progress report dated 10/28/15. The request is for CT myelogram lumbar spine. There is no RFA for this case, and the patient's date of injury is 02/27/06. Diagnoses, as per progress report dated 10/28/15, included lumbar disc herniation with associated facet joint hypertrophy, HNP at L4-5 and L5-S1 with central and foraminal stenosis, left lower extremity radiculopathy, reactionary anxiety and depression, coronary artery disease, uncontrolled hypertension, three-level positive proactive discography, medication-induced gastritis, and right lateral epicondylitis. Physical examination of the lumbar spine revealed tenderness to palpation, multiple trigger points, and reduced range of motion, along with positive straight leg raise and decreased sensation along the L5-S1 dermatomes on the left. Medications included Oxycontin, Roxycodone, Norco, Neurontin, Prozac, Prilosec, Soma, and Lidoderm patches. The patient is temporarily totally disabled, as per the same report. ODG guidelines, low back chapter under Computed Tomography (CT scan) states: "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. ODG Guidelines, low back chapter under lumbar myelogram states: "myelography is not recommended except for selected indication such as cerebrospinal fluid leak, surgical planning, radiation therapy planning for tumors, evaluation of spinal or basal cisternal disease/infection, poor correlation with physical finding with MRI and if MRI cannot be tolerated/surgical hardware present." In this case, the patient underwent a lumbar MRI on 04/09/15, which revealed disc herniation at L4-5 with central and bilateral recess stenosis and neural foraminal stenosis; and deviating left S1 transiting nerve contacting the left L5 nerve, as per progress report dated 10/28/15. The patient also underwent lumbar MRIs in 2009 and 2007. In progress report dated 07/14/15, the treater states that the patient needs an MRI along with flexion and extension films due to "progressive neurogenic claudication symptoms," but this request was denied. The treater is, therefore, requesting for a CT myelogram in multiple reports since then, including the 10/28/15 report, as they are "looking for foraminal as well as central stenosis to check the patient's increased radicular neurogenic claudication symptoms." The 04/09/15 MRI has, nonetheless, confirmed the presence of central and foraminal stenosis. It is not clear why the patient needs a CT myelogram now. ODG supports the use of myelograms only if there is "poor correlation with physical finding with MRI and if MRI cannot be tolerated/surgical hardware present." Hence, the request is not medically necessary.