MAXIMUS Federal Services

Case Number:	CM15-0095964		
Date Assigned:	05/22/2015	Date of Injury:	07/11/2008
Decision Date:	07/02/2015	UR Denial Date:	05/11/2015
Priority:	Standard	Application Received:	05/18/2015

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 57-year-old male who sustained an industrial injury on 7/11/08 while using a jack to lift a transmission; the jack slipped causing him to be knocked to the ground causing low back pain. He has had a prior low back injury and surgery in 2004 with resolution of back and leg pain. There was residual low back pain and primarily left leg radicular pain. He had a headache (6/10) post-operatively from a central spinal fluid leak. He currently has no back or leg pain. He has some pain with active range of motion of the lumbar spine. He has some knee pain that limits active range of motion, mild numbness leg foot in an L5/S1 distribution and some posterior calf numbness. On direct palpation over L3/4, L4/5 and L5/S1 facet joints there was pain. Diagnoses include status post bilateral L4/5 and L5/S1 laminotomy, foraminotomy (10/20/14); sacroilitis; spinal stenosis of the lumbar region without neurogenic claudication. Treatments to date include 24 visits of physical therapy, acupuncture, epidural steroid injections without lasting relief; sacroiliac joint injection (3/11/15) with 60% relief of pain. Diagnostics include MRI lumbar spine (2/23/11) showing evidence of prior surgery and left lumbar scoliosis; MRI lumbar spine (5/8/09) with abnormal results; electromyography/ nerve conduction study bilateral lower extremities which were reviewed in the 9/25/14 progress note; MRI lumbar spine (2/13/15). In the progress note dated 5/7/15 the treating providers of care includes computed tomography myelogram lumbar spine and electromyography/ nerve conduction study of the bilateral lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Computerized Tomography (CT) Myelogram 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 Official Disability Guidelines (ODG), myelography and ct myelography, low back lumbar and thoracic (acute and chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Criteria for Myelography and CT Myelography.

Decision rationale: According to ODG guidelines, Myelography Not recommended except for selected indications below, when MR imaging cannot be performed, or in addition to MRI. Myelography and CT Myelography OK if MRI unavailable, contraindicated (e.g. metallic foreign body), or inconclusive. (Slebus, 1988) (Bigos, 1999) (ACR, 2000) (Airaksinen, 2006) (Chou, 2007) Invasive evaluation by means of myelography and computed tomography myelography may be supplemental when visualization of neural structures is required for surgical planning or other specific problem solving. (Seidenwurm, 2000) Myelography and CT Myelography have largely been superseded by the development of high resolution CT and magnetic resonance imaging (MRI), but there remain the selected indications below for these procedures, when MR imaging cannot be performed, or in addition to MRI. (Mukherji, 2009)ODG: 1. Demonstration of the site of a cerebrospinal fluid leak (postlumbar puncture headache, postspinal surgery headache, rhinorrhea, or otorrhea). 2. Surgical planning, especially in regard to the nerve roots; a myelogram can show whether surgical treatment is promising in a given case and, if it is, can help in planning surgery. 3. Radiation therapy planning, for tumors involving the bony spine, meninges, nerve roots or spinal cord. 4. Diagnostic evaluation of spinal or basal cisternal disease, and infection involving the bony spine, intervertebral discs, meninges and surrounding soft tissues, or inflammation of the arachnoid membrane that covers the spinal cord. 5. Poor correlation of physical findings with MRI studies. 6. Use of MRI precluded because of: a. Claustrophobia; b. Technical issues e.g., patient size; c. Safety reasons e.g., pacemaker; d. Surgical hardware Lumbar myelogram is indicated in case of disc herniation, tumor and spinal cord compression, especially when the MRI is contraindicated or provided limited information. There is no clinical evidence suggesting that the patient has a contraindication to use MRI. Furthermore, there is no evidence that the patient MRI provided limited information. There is no evidence that the patient one of the ODG conditions mentioned above. Therefore, the request for a Computerized Tomography (CT) Myelogram of the lumbar spine is not medically necessary.

EMG/NCV of bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), low back lumbar and thoracic (acute and chronic), EMG, NCS.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: According to MTUS guidelines, (MTUS page 303 from ACOEM guidelines), Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. EMG has excellent ability to identify abnormalities related to disc protrusion (MTUS page 304 from ACOEM guidelines). According to MTUS guidelines, needle EMG study helps identify subtle neurological focal dysfunction in patients with neck and arm symptoms. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks (page 178). EMG is indicated to clarify nerve dysfunction in case of suspected disc herniation (page 182). EMG is useful to identify physiological insult and anatomical defect in case of neck pain (page 179). In this case, the patient had an EMG/NCV study of BLE performed on September 17, 2014 with findings of chronic lumbar radiculopathy that were essentially similar to the electro diagnostic findings in 2013. There is no documentation of significant change in symptoms and/or new findings suggestive of a new pathology. Therefore, the request for EMG/NCV study of the bilateral lower extremities is not medically necessary.