

Case Number:	CM15-0097054		
Date Assigned:	05/27/2015	Date of Injury:	08/22/2004
Decision Date:	06/25/2015	UR Denial Date:	05/06/2015
Priority:	Standard	Application Received:	05/19/2015

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 48 year old female who sustained a work related injury August 22, 2004. Past history included discectomy July 2005, laminectomy July 2006, and a lumbar fusion, December 2006, mild hypertension, diabetes, and spinal cord stimulator. According to a treating physician's progress notes, dated April 3, 2015, the injured worker presented with complaints of low back pain with radiation into the lower extremities. The physician documents the battery has failed on the stimulator. Objective findings included dysesthesias in both the L5 and S1 distributions, straight leg raise positive bilaterally, sacroiliac joints are mildly tender, and the lumbar paraspinal muscles are moderately tender to deep palpation. Assessment is documented as failed surgery syndrome; lumbar radiculopathy; chronic lumbar pain. At issue is the request for authorization for a CT Myelogram of the thoracic spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Computed tomography myelogram of the thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines,

Low Back - Lumbar & Thoracic (updated 04/29/15) Online Version- CT (computed tomography).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation CT (computed tomography). <http://www.odg-twc.com/index.html> Myelography <http://www.odg-twc.com/index.html>.

Decision rationale: According to ODG guidelines, CT (computed tomography) is indicated: 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 (Laasonen, 1989), Furthermore and according to ODG, 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 Criteria for Myelography and CT Myelography: 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. There is no documentation that the patient cannot do MRI or have an inconclusive MRI. Furthermore, there is no documentation of recent traumatic neurological deficit, planned radiation therapy or any other indication for CT myelogram. Therefore, the request for Computed tomography myelogram of the thoracic spine is not medically necessary.

Computed tomography with contrast material of the thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (updated 04/29/15) Online Version- CT (computed tomography).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation CT (computed tomography). <http://www.odg-twc.com/index.html> Myelography <http://www.odg-twc.com/index.html>.

Decision rationale: According to ODG guidelines, CT (computed tomography) is indicated: 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 (Laasonen, 1989) Furthermore and according to ODG, 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 Criteria for Myelography and CT Myelography: 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. There is no documentation that the patient cannot do MRI or have an inconclusive MRI. Furthermore, there is no documentation of recent traumatic neurological deficit, planned radiation therapy or any other indication for CT myelogram. Therefore, the request for Computed tomography with contrast material of the thoracic spine is not medically necessary.