
Notice of Independent Medical Review Determination

Dated: 12/9/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	8/22/2013
Date of Injury:	7/1/2003
IMR Application Received:	8/28/2013
MAXIMUS Case Number:	CM13-0017666

- 1) MAXIMUS Federal Services, Inc. has determined the request for **lumbar myelogram is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **EMG right upper extremity with paraspinal area is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **EMG left upper extremity with paraspinal area is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **NCS right upper extremity is medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **NCS left upper extremity is medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **CT myelogram, cervical (completeness sake in showing upper extremity radiculopathy) is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/28/2013 disputing the Utilization Review Denial dated 8/22/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **lumbar myelogram is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **EMG right upper extremity with paraspinal area is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **EMG left upper extremity with paraspinal area is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **NCS right upper extremity is medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **NCS left upper extremity is medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **CT myelogram, cervical (completeness sake in showing upper extremity radiculopathy) is medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Preventative Medicine and Occupational Medicine, 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 treatments and/or services at issue.

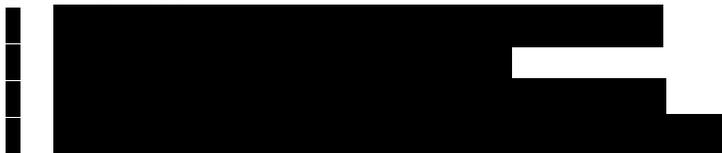
Expert Reviewer Case Summary:

The applicant is a 51-year-old female who was injured on 7/1/2003 and presents with chronic neck and low back pain. The applicant has been treated with analgesic medications, including long-acting opioids, transfer of care to and from various providers, physical therapy, adjuvant medications, psychotropic medications, and epidural steroid injections. MRI imaging of the cervical spine in May 2012 was notable for a disc protrusion at C6-7. A note of 7/29/2013 is notable for comments that the applicant needs cervical spine surgery. A note dated 9/10/2013 is notable for comments that the applicant's spine surgeon has recommended cervical spine surgery. The applicant is described as exhibiting diminished upper extremity strength score of 4/5. It is stated that electrodiagnostic testing and possible CT myelogram are needed to objectify the radiculopathy previously established at C6-7. A note dated 9/23/2013 is

notable for comments that the applicant reports persistent neck and shoulder pain as well as low back pain radiating to the left leg. The applicant reports left lower extremity sciatica. She is presently on methadone, Ambien, and Doxepin.

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:



1) Regarding the request for lumbar myelogram:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) Web, 11th Edition-Low Back, which is not a part of the MTUS.

The Expert Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12), Table 12-8, which is a part of the MTUS.

Rationale for the Decision:

As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, Table 12-8, CT myelography can be employed for preoperative planning purposes if MRI imaging is unavailable. A review of the records indicates in this case, it does not appear that the employee is actively contemplating surgery involving the lumbar spine. Rather, the bulk of the complaints and symptoms seemingly pertain to the upper extremities and cervical spine. Pursuing optional CT myelography of the lumbar spine without any clear intention of pursuing a surgical remedy is not medically necessary, medically appropriate, or indicated here. **The request for lumbar myelogram is not medically necessary and appropriate.**

2) Regarding the request for EMG right upper extremity with paraspinal area:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the ACOEM Guidelines, 2nd Edition, 2004, pg.177-178, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), Table 8-8, which is a part of the MTUS.

Rationale for the Decision:

As noted in the MTUS-adopted ACOEM Guidelines in Chapter 8, Table 8-8, EMG testing can be employed to clarify diagnosis of nerve root dysfunction in case there is suspected disc herniation preoperatively or before epidural steroid injection. A review of the records indicates that in this case, the employee has some evidence of radiographically confirmed cervical radiculopathy with a disc protrusion at C6-C7. This is causing mild narrowing of the spinal canal. It is not clear that this is the source of the employee's ongoing upper extremity radicular complaints. Performing electrodiagnostic testing to definitively establish the diagnosis of radiculopathy prior to consideration of cervical spine surgery is therefore indicated in this context. Accordingly, the original utilization review decision is overturned. **The request for EMG right upper extremity with paraspinal area is medically necessary and appropriate.**

3) Regarding the request for EMG left upper extremity with paraspinal area:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the ACOEM Guidelines, 2nd Edition, 2004, pg. 177-178, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), Table 8-8, which is a part of the MTUS.

Rationale for the Decision:

A review of the records indicates that the employee has some incomplete evidence of radiculopathy noted on prior cervical MRI imaging. This does demonstrate equivocal evidence of spinal stenosis at C6-C7, superimposed on a disc protrusion at that level. Obtaining electrodiagnostic testing to help definitively establish the diagnosis of radiculopathy is indicated and appropriate in this context. Accordingly, the original utilization review decision is overturned. **The request for EMG left upper extremity with paraspinal area is medically necessary and appropriate.**

4) Regarding the request for NCS right upper extremity:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the ACOEM Occupational Medicine Practice Guidelines, 2nd Edition, 2004, pg. 238, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), Special Studies, pg. 177-178, which is a part of the MTUS.

Rationale for the Decision:

As noted in the MTUS-adopted ACOEM Guidelines in Chapter 8, EMG and/or NCV studies may help identify subtle focal neurologic dysfunction in those applicants with persistent neck and/or arm complaints. A review of the records indicates, in this case, the employee has longstanding neck and arm complaints. She is actively contemplating cervical spine surgery. Obtaining electrodiagnostic testing to help definitively establish the diagnosis of radiculopathy and/or possibly uncover other sources of upper extremity pain is indicated. Accordingly, the original utilization review decision is overturned. **The request for NCS right upper extremity is medically necessary and appropriate.**

5) Regarding the request for NCS left upper extremity:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the ACOEM Occupational Medicine Practice Guidelines, 2nd Edition, 2004, pg. 238, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), Special Studies, pg. 177-178, which is a part of the MTUS.

Rationale for the Decision:

The MTUS-adopted ACOEM Guidelines in Chapter 8 endorse both EMG and NCV testing to help identify subtle focal neurologic dysfunction in applicants with neck and arm symptoms that last greater than three to four weeks. A review of the records indicates that in this case, the employee has longstanding neck and arm complaints. Obtaining electrodiagnostic testing to help definitively establish the diagnosis of cervical radiculopathy and/or possibly uncover other sources of upper extremity pathology is indicated, in light of the fact that the claimant is intent on pursuing cervical spine surgery. Accordingly, the original utilization review decision is overturned. **The request for NCV left upper extremity is medically necessary and appropriate.**

6) Regarding the request for CT myelogram, cervical (completeness sake in showing upper extremity radiculopathy):

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Web, 11th Edition, Neck and Upper Back Section, which is not part of MTUS.

The Expert Reviewer based his/her decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), Table 8-7, Neck and Upper Back Pathology, pg. 179, which is a part of the MTUS.

Rationale for the Decision:

A review of the records indicated that the employee has some incomplete evidence of radiculopathy noted on MRI imaging of the cervical spine of May 2012. The employee is actively contemplating spine surgery, having failed all other lower levels of care. As noted in the MTUS-adopted ACOEM Guidelines in Chapter 8, Table 8-7, myelography and/or CT myelography are scored a 4/4 in their ability to identify and define anatomic defects. In this case, it is very critical to help clearly delineate the presence or absence of anatomic defects as the claimant's decision to pursue cervical spine surgery or not is contingent on the outcome of these studies. Accordingly, the original utilization review decision is overturned. **The request for CT myelogram, cervical (completeness sake in showing upper extremity radiculopathy) is medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations



/sab

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.