

Case Number:	CM14-0010241		
Date Assigned:	02/21/2014	Date of Injury:	10/04/2011
Decision Date:	08/01/2014	UR Denial Date:	01/16/2014
Priority:	Standard	Application Received:	01/23/2014

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 Physical Medicine and Rehabilitation, and is licensed to practice in Illinois. 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:

The injured worker is a 63-year-old male who reported an injury on 10/04/2011 with a mechanism of injury not cited within the documentation provided. In the clinical note dated 01/06/2014, the injured worker complained of ongoing neck and low back pain at which he rated an 8/10 to 9/10 on VAS. Prior treatments included physical therapy and 2 years of activity modifications and prescribed medications. The injured worker's prescribed pain medication regimen included Anaprox DS 550 mg, Norco 5/325 mg tablets, Ultram 50 mg, MiraLax powder 17 gm/dose and Amitiza 24 mcg capsules. The physical examination of the cervical spine and upper extremities revealed no swelling or gross atrophy of the paracervical muscles and no evidence of tilt torticollis. There was also no evidence of tenderness of the cervicothoracic junction. It was annotated that in unofficial MRI of the cervical spine dated 04/30/2012 revealed imaging at C2-3, there was no focal posterior disc herniation or stenosis identified; at C3-4, there was mild posterior endplate ridging and annular bulge and possible focal small about 2 mm central broad-based disc protrusion, slightly flattening the anterior thecal margin; no foraminal narrowing identified; mild facet degenerative changes. At C4-5, posterior endplate ridging and annular bulge were seen with a somewhat more prominent about 3 mm central and right paracentral disc protrusion mildly flattening the anterior thecal margin and narrowing the anterior subarachnoid space with mild thecal sac narrowing. It was noted there was no foraminal narrowing identified. There were also mild facet degenerative changes. At C5-6, posterior endplate ridging and annular bulge were seen with more focal small about 2 mm central broad-based disc protrusion mildly flattening the anterior thecal margin and narrowing the anterior subarachnoid space with mild thecal sac narrowing. It was noted there was no foraminal narrowing identified. At C6-7, mild posterior endplate ridging and annular bulge were noted. There was also slight anterior thecal margin flattening and thecal sac narrowing. There was no

foraminal narrowing identified. At C7-T1, mild posterior endplate ridging and annular bulge were noted with slightly flattening of the anterior thecal margin. There was no gross thecal sac or foraminal narrowing identified. The diagnoses included L4-5 spondylolisthesis; hernia on the right lower quadrant, non industrial; facet arthropathy C3-C6; L5-S1 degenerative disc disease with severe disc space collapse; C5-6 disc degeneration with significant osteophyte formation; C3-T1 severe degenerative disc disease; left wrist contusion, healed; and status post hernia repair, non industrial. It was noted that the injured worker had failed conservative measures to include therapy and 2 years of activity modifications. Facet blocks were non-diagnostic and x-rays showed degeneration primarily at C5-6 and unofficial MRI scan showed degeneration at C4-C7 without spinal cord compression or significant stenosis. The treatment plan included a request for pain management consultation and diagnostic discogram from C4 to C7. A request was also made for a soft cervical collar and to followup in 4 to 6 weeks. It was noted that the physician believed the injured worker was a candidate for C5-6 discectomy and fusion with cage and instrumentation and stated that a discogram would be the test to determine the injured worker's pain generator more accurately. The request for authorization was annotated within the clinical documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

CERVICAL DIAGNOSTIC DISCOGRAPHY AT THE LEVELS OF C4-7: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS ODG, Low Back Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper back, Discography.

Decision rationale: The request for cervical diagnostic discography at the levels of C4-7 is not medically necessary. The ODG state that discography is not recommended. Conflicting evidence exists in this area, though some recent studies condemn its use as a preoperative indication for IDET or fusion, and indicate that discography may produce symptoms in control groups more than a year later, especially in those with emotional and chronic pain problems. Patient selection criteria for discography if provider and payor agree to perform anyway include neck pain of 3 or more months; failure of recommended conservative treatment; an MRI demonstrating one or more degenerated discs as well as one or more normal appearing discs to allow for an internal control injection (injection of a normal disc to validate the procedure by a lack of a pain response to that injection); satisfactory results from psychosocial assessment (discography in subjects with emotional and chronic pain has been associated with reports of significant prolonged back pain after injection, and thus should be avoided); should be considered a candidate for surgery; should be briefed on potential risks and benefits both from discography and from surgery; and due to high rates of positive discogram after surgery for disc herniation, this should be potential reason for non certification. In the clinical notes provided for review, there is a lack of documentation of the injured worker having neurological or functional deficits to include range of motion within the physical examination of the cervical spine. Furthermore, the guidelines do not recommend

discography due to its potential to produce symptoms in injured workers with emotional and chronic pain problems. Therefore, the request for cervical diagnostic discography at the levels of C4-7 is not medically necessary.