

<b>Case Number:</b>	CM14-0018660		
<b>Date Assigned:</b>	05/09/2014	<b>Date of Injury:</b>	11/28/1995
<b>Decision Date:</b>	07/09/2014	<b>UR Denial Date:</b>	01/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2014

### 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 & Rehabilitation, 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 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 patient is a 47 year old male who sustained an injury on 11/28/1995. Prior treatment history has included baclofen 10 mg, hydrocodone/acetaminophen (APAP) 10/325 mg, trigger point injections, multiple cervical epidural steroid injections; physical therapy, massage therapy and medication management. MR of the C-spine without contrast dated 10/04/2013 reveals 1) At C5- C6, there is moderate central canal and mild to moderate bilateral foraminal stenosis and 2) At C3-C4 and C5-C6, there is mild to moderate central canal and bilateral foraminal stenosis. Pain and rehab note dated 01/23/2014 states the patient complains of neck pain. He states his neck pain is worse and he is waking up in the middle of the night. He has difficulty with turning his head to the right because of the pain. He has difficulty with turning his head to the right as well as difficulty turning his shoulders and neck because of pain. He reports the pain radiates to the right upper extremity to the forearm and is associated with numbness and tingling in the right hand. Objective findings on exam reveal spinous process tenderness at C4-C5 and C6-C7. He has increased pain on flexion at 20 degrees; extension at 20 degrees and on rotation at 30 degrees at the cervical spine. Paravertebral muscle examination of both sides shows tenderness. Trapezius muscle examination on both sides show tenderness. There is a mild decrease in sensation to light touch in the right C6 and C7 dermatomes. The diagnoses are 1) Cervical spinal stenosis 2) Degeneration cervical disc 3) Therapeutic drug monitor 4) neck pain and 5) Idiopathic scoliosis and Kyphoscoliosis of the thoracic spine. Prior UR dated 01/14/2014 states the request for a cervical myelography is not certified as there is no evidence to support the necessity of the procedure.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**CERVICAL MYELOGRAPHY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178-179.

**Decision rationale:** According to the CA MTUS/ACOEM guidelines, the ability of myelography to identify and define neck and upper back pathology is 0 to Identify Physiologic Insult, and Identify Anatomic Defect. According to the Official Disability Guidelines, myelography is not recommended except for selected indications below, when MR imaging cannot be performed, or in addition to MRI. Myelography and CT Myelography has largely been superseded by the development of high resolution CT and magnetic resonance imaging (MRI), but there remain the selected indications for these procedures, when MR imaging cannot be performed, or in addition to MRI: 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. According the medical records, the patient had been authorized to undergo C5- 6 and C6-7 epidural steroid injection with fluoroscopy, which was performed on 3/4/14. The guidelines do not indicate myelography is recommended or medically indicated for the performance of an epidural steroid injection. The medical records do not document why CT myelography is needed, since the patient has also already previously undergone a cervical MRI on 11/4/2013. The medical records do not establish any of the indications for myelogram exist in this case. As per the ODG, Myelography is not recommended except for selected indications, which has not been demonstrated in this case.

