

Case Number:	CM14-0160308		
Date Assigned:	10/03/2014	Date of Injury:	04/10/2012
Decision Date:	11/25/2014	UR Denial Date:	08/20/2014
Priority:	Standard	Application Received:	09/29/2014

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 Emergency Medicine and is licensed to practice in Texas. 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 54-year-old female who reported an injury on 04/10/2012. The injured worker sustained an injury while removing a crib when a strap on the crib broke. The injured worker fell backwards and tried to catch the fall by grabbing the chain link fence. The injured worker fell back against the wall, hitting the right side of her body and right side of her head on the pole. The injured worker's treatment history included cervical epidural steroid injections, x-rays of the cervical spine, MRI studies of the right shoulder, MRI study of the cervical spine, and medications. The injured worker had undergone an x-ray of the cervical spine on 03/05/2013 that revealed slight reversal of usual neutral lordosis and anterior ligamentous calcification at C4-5 and mild posterior spurring at C5-6, with low-normal height of the C5-6 disc space and very minimal spur encroachment on the C5-6 neural foramina bilaterally, slightly greater on the right. The injured worker had undergone an MRI of the cervical spine dated 01/02/2014 that revealed at C5-6, degenerative disc in osteophyte disease resulted in effacement of the ventral cord without canal stenosis. No focal cord signal abnormality. There was additional mild bilateral neural foraminal narrowing at this level and mild degenerative disease at C6-7 without cord effacement or neural foraminal narrowing. (The injured worker was evaluated on 08/05/2014, and was documented the injured worker complained of constant neck pain rated at 7/10 to 8/10, with associated headaches rated at 3/10 on the pain scale. The injured worker complained of dizziness while lying down. The neck pain worsened with movement. The injured worker complained of right shoulder pain rated at 4/10. On physical examination of the cervical spine, there was evidence of tenderness of the bilateral cervical paraspinal muscles. There was tenderness over the trapezius musculature bilaterally. There was tenderness over the upper interscapular space. There was decreased sensation over the right C6 dermatome distribution. The cervical range of motion in flexion was 30 degrees, extension was 10 degrees,

left lateral bend was 25 degrees, right lateral bend was 25 degrees, left rotation was 45 degrees, and right rotation was 45 degrees. Hoffmann's test was negative. The motor strength was 5/5 in all areas and reflexes were 1+ at the biceps, triceps, and brachioradialis. The injured worker had an neurology consultation dated 06/13/2014, the provider documented the injured worker's headache is due to trauma she sustained to occipital head region, as well as related to musculoskeletal dysfunction, cervical region, which triggers headaches. Diagnoses included right shoulder impingement syndrome and acromioclavicular (AC) joint arthritis, C5-6 disc degeneration, C5-6 stenosis, vertigo, tinnitus, cervicogenic headaches, and closed head injury. The Request for Authorization dated 08/05/2014 was for diagnostic discogram at C5-6 and C6-7 with negative control. It was documented that the injured worker had failed all conservative measures to date, including physical therapy, acupuncture therapy, chiropractic therapy, epidural steroid injections, and activity modifications, including being off from work since 05/2014. The injured worker had also tried Fioricet which was not helpful. The injured worker may be a candidate for surgical intervention but the requested diagnostic study would not be appropriate.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diagnostic Discogram at C5-C6 and C6-C7 with Negative Control: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG Neck & Upper Back (updated 08/04/14) Discography

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back. Discography

Decision rationale: The request for diagnostic discogram at C5-C6 and C6-C7 with negative control is not medically necessary. According to ACEOM Discography is frequently used prior to cervical fusions and certain disk-related procedures. There is significant scientific evidence that questions the usefulness of discography in those settings. While recent studies indicate discography to be relatively safe and have a low complication rate, some studies suggest the opposite to be true. In any case, clear evidence is lacking to support its efficacy over other imaging procedures in identifying the location of cervical symptoms, and, therefore, directing intervention appropriately. Tears may not correlate anatomically or temporally with symptoms. Because this area is rapidly evolving, clinicians should consult the latest available studies. Furthermore, the Official Disability Guidelines (ODG) does not recommend Discography 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.) Cervical discography has been used to assist in determining the specific level or levels causing the neck pain and, potentially, which levels to fuse; however, controversy regarding the specificity of cervical discograms has also been debated and more research is needed. Assessment tools such as discography lack validity and utility. Although discography, especially combined with CT scanning, may be more accurate than other radiologic studies in detecting degenerative disc disease, its ability to improve surgical outcomes has yet to be proven.

It is routinely used before IDET, yet only occasionally used before spinal fusion. Patient selection criteria for Discography if provider & payor agree to perform anyway: 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 & 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. Due to high rates of positive discogram after surgery for disc herniation, this should be potential reason for non-certification. As such, the request for diagnostic discogram at C5-6 and C6-7 with negative control is not medically necessary.