Case Number:	CM14-0179655		
Date Assigned:	11/04/2014	**Date of Injury:**	11/14/2011
Decision Date:	12/10/2014	**UR Denial Date:**	10/08/2014
Priority:	Standard	**Application Received:**	10/29/2014

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 Occupational Medicine and is licensed to practice in Montana. 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 caregiver at a senior living facility with a date of injury of 11/14/11. Her initial injury involved the left elbow when she was moving a resident. Within a few days she had pain in the neck, left shoulder and left arm. Treatment has included physical therapy, acupuncture, e-stim and 3 epidural steroid injections. Medications have included Motrin and Flexeril and Xanax. Her current diagnoses include cervical/trapezius strain with myofasciitis, cervical radiculopathy, and cervical spondylolisthesis at C3-4 and C4-5 with minimal effacement of the thecal sac, left shoulder pain status post manipulation under anesthesia and arthroscopic acromioplasty, left elbow pain status post left ulnar nerve transposition, and left carpal tunnel syndrome. An Agreed Medical Examination on 9/23/14 noted that future medical care would include electrodiagnostic testing as indicated if symptoms worsen, ongoing medication, 2 physical therapy visits to establish a home exercise program, 1 physical therapy (PT) visit every 3 months for updates for 2 years, and periodic orthopedic follow-up. No surgery is recommended. The primary treating physician has requested cervical myelogram, 3-D CT scan, and AP/LAT cervical x-rays.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical Myelogram: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck, Myelography

Decision rationale: The MTUS states that, for most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. Criteria for ordering imaging studies are: Emergence of a red flag; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery; and clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear; however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. In the following circumstances, an imaging study may be appropriate for a patient whose limitations due to consistent symptoms have persisted for four to six weeks or more: When surgery is being considered for a specific anatomic defect; and to further evaluate the possibility of potentially serious pathology, such as a tumor. Reliance on imaging studies alone to evaluate the source of neck or upper back symptoms carries a significant risk of diagnostic confusion (false-positive test results) because it's possible to identify a finding that was present before symptoms began and, therefore, has no temporal association with the symptoms. The Official Disability Guidelines (ODG) does not recommend cervical myelography except for selected indications below, when MR imaging cannot be performed, or in addition to MRI. Myelography or CT-myelography may be useful for preoperative planning. 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: demonstration of the site of a cerebrospinal fluid leak (postlumbar puncture headache, post-spinal surgery headache, rhinorrhea, or otorrhea); 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; radiation therapy planning, for tumors involving the bony spine, meninges, nerve roots or spinal cord; 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; poor correlation of physical findings with MRI studies; and use of MRI precluded because of: Claustrophobia; technical issues, e.g., patient size; safety reasons, e.g., pacemaker; and surgical hardware. In this case, the medical records do not document red flag conditions, surgical indications, or concern about other potentially serious pathology. The request for cervical myelogram is not consistent with the MTUS and Official Disability Guidelines (ODG); therefore, the request is not medically necessary.

3D CAT scan: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck, Computed Tomography

Decision rationale: The MTUS states that, for most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. Criteria for ordering imaging studies are: emergence of a red flag; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery; clarification of the anatomy prior to an invasive procedure; and physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. In the following circumstances, an imaging study may be appropriate for a patient whose limitations due to consistent symptoms have persisted for four to six weeks or more: When surgery is being considered for a specific anatomic defect; to further evaluate the possibility of potentially serious pathology, such as a tumor. Reliance on imaging studies alone to evaluate the source of neck or upper back symptoms carries a significant risk of diagnostic confusion (false-positive test results) because it's possible to identify a finding that was present before symptoms began and, therefore, has no temporal association with the symptoms. The Official Disability Guidelines (ODG) does not recommend 3D CT scan except for indications below. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, and have no neurologic findings, do not need imaging. Patients who do not fall into this category should have a three-view cervical radiographic series followed by computed tomography (CT). In determining whether or not the patient has ligamentous instability, magnetic resonance imaging (MRI) is the procedure of choice, but MRI should be reserved for patients who have clear-cut neurologic findings and those suspected of ligamentous instability. See also ACR Appropriateness Criteria. MRI or CT imaging studies are valuable when potentially serious conditions are suspected like tumor, infection, and fracture, or for clarification of anatomy prior to surgery. MRI is the test of choice for patients who have had prior back surgery. For the evaluation of the patient with chronic neck pain, plain radiographs (3-view: anteroposterior, lateral, open mouth) should be the initial study performed. Patients with normal radiographs and neurologic signs or symptoms should undergo magnetic resonance imaging. If there is a contraindication to the magnetic resonance examination such as a cardiac pacemaker or severe claustrophobia, computed tomography myelography, preferably using spiral technology and multiplanar reconstruction is recommended. CT scan has better validity and utility in cervical trauma for high-risk or multi-injured patients. Repeat CT is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g. tumor, infection, fracture, neurocompression, recurrent disc herniation where MRI is contraindicated). Indications for imaging -- CT (computed tomography):

Suspected cervical spine trauma, alert, cervical tenderness, paresthesias in hands or feet; suspected cervical spine trauma, unconscious; suspected cervical spine trauma, impaired sensorium (including alcohol and/or drugs); known cervical spine trauma: severe pain, normal plain films, no neurological deficit; known cervical spine trauma: equivocal or positive plain films, no neurological deficit; and known cervical spine trauma: equivocal or positive plain films with neurological deficit. In this case, the medical records do not document red flag conditions, surgical indications, or concern about other potentially serious pathology. There is no evidence for cervical spine trauma. The request for 3-D CAT scan is not consistent with the MTUS and Official Disability Guidelines (ODG); therefore, this request is not medically necessary.

AP/LAT X-ray: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck, Radiography (X-rays)

Decision rationale: The MTUS states that, for most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. Criteria for ordering imaging studies are: Emergence of a red flag; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery; and clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. In the following circumstances, an imaging study may be appropriate for a patient whose limitations due to consistent symptoms have persisted for four to six weeks or more: when surgery is being considered for a specific anatomic defect; and to further evaluate the possibility of potentially serious pathology, such as a tumor. Reliance on imaging studies alone to evaluate the source of neck or upper back symptoms carries a significant risk of diagnostic confusion (false-positive test results) because it's possible to identify a finding that was present before symptoms began and, therefore, has no temporal association with the symptoms. The Official Disability Guidelines ODG does not recommend cervical X-rays except for indications below. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, and have no neurologic findings, do not need imaging. Patients who do not fall into this category should have a three-view cervical radiographic series followed by computed tomography (CT). In determining whether or not the patient has ligamentous instability, magnetic resonance imaging (MRI) is the procedure of choice, but MRI should be reserved for patients who have clear-cut neurologic findings and those suspected of ligamentous instability. See also ACR Appropriateness Criteria. Initial studies may be warranted only when potentially serious

underlying conditions are suspected like fracture or neurologic deficit, cancer, infection or tumor. For the evaluation of the patient with chronic neck pain, plain radiographs (3-view: anteroposterior, lateral, open mouth) should be the initial study performed. Patients with normal radiographs and neurologic signs or symptoms should undergo magnetic resonance imaging. If there is a contraindication to the magnetic resonance examination such as a cardiac pacemaker or severe claustrophobia, computed tomography myelography, preferably using spiral technology and multiplanar reconstruction is recommended. There is little evidence that diagnostic procedures for neck pain without severe trauma or radicular symptoms have validity and utility. Indications for imaging X-rays (AP, lateral, etc.): Cervical spine trauma, unconscious; cervical spine trauma, impaired sensorium (including alcohol and/or drugs); cervical spine trauma, multiple trauma and/or impaired sensorium; cervical spine trauma (a serious bodily injury), neck pain, no neurological deficit; cervical spine trauma, alert, cervical tenderness, paresthesias in hands or feet; cervical spine trauma, alert, cervical tenderness; chronic neck pain (= after 3 months conservative treatment), patient younger than 40, no history of trauma, first study; chronic neck pain, patient younger than 40, history of remote trauma, first study; chronic neck pain, patient older than 40, no history of trauma, first study; chronic neck pain, patient older than 40, history of remote trauma, first study; chronic neck pain, patients of any age, history of previous malignancy, first study; chronic neck pain, patients of any age, history of previous remote neck surgery, first study; and post-surgery: evaluate status of fusion. In this case, the medical records do not document red flag conditions, surgical indications, or concern about other potentially serious pathology. An MRI has already been performed. The request for AP/LAT X-ray is not consistent with the MTUS and Official Disability Guidelines (ODG); therefore, this request is medically necessary.