

<b>Case Number:</b>	CM15-0173423		
<b>Date Assigned:</b>	09/16/2015	<b>Date of Injury:</b>	03/31/2009
<b>Decision Date:</b>	10/22/2015	<b>UR Denial Date:</b>	08/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/02/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Texas, New York, California  
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 applicant is a represented [REDACTED] beneficiary who has filed a claim for chronic neck pain reportedly associated with an industrial injury of March 31, 2009. In a Utilization Review report dated August 11, 2014, the claims administrator failed to approve a request for a CT myelogram of the lumbar spine. The claims administrator referenced an August 4, 2015 RFA form and an associated July 13, 2015 office visit in its determination. Non-MTUS ODG Guidelines were invoked, despite the fact that the MTUS addresses the topic. The applicant's attorney subsequently appealed. On June 19, 2015, the applicant reported ongoing complaints of neck pain, exacerbated by lifting, reaching, pushing, and pulling. The applicant reported associated headaches. 8/10 pain complaints were reported. The applicant reported radiation of neck pain to bilateral upper extremities. The applicant exhibited 3+ to 4-/5 upper extremity strength with associated dysesthesias appreciated about the upper extremities on exam. The applicant was apparently pending cervical spine surgery, it was reported. There was no mention of the need for CT myelography on this date. On June 1, 2015, the applicant was asked to consult a cervical spine surgeon. On July 13, 2015, the applicant reported insidious onset neck pain radiating into the bilateral upper extremities, progressively worsening over time. The applicant had had prior lumbar spine surgery, it was reported. The applicant was given diagnosis of cervical radiculopathy and cervical degenerative disk disease. The attending provider acknowledged that the applicant had previously had MRI imaging of the spine and electrodiagnostic testing of the bilateral upper extremities, the results of which were not seemingly reported. Toward the bottom of the note, the attending provider sought authorization for CT myelogram of the cervical

spine. In a separate report dated July 13, 2015, the attending provider seemingly suggested that he was seeking CT myelography on the grounds that this would help him to better define the structural issues in the neck prior to consideration of cervical spine surgery. The attending provider stated a medical-legal evaluator had also endorsed cervical spine surgery. Cervical MRI imaging of November 17, 2014 was notable for mild-to-moderate left-sided neuroforaminal stenosis at C3-C4, moderate left-sided neuroforaminal stenosis and mild right-sided neuroforaminal stenosis at C5-C6, mild left-sided neuroforaminal stenosis at C7-T1, and the absence of any definitive cervical spinal cord abnormality. Electrodiagnostic testing of November 20, 2014 was notable for moderate severe right-sided carpal tunnel stenosis, moderate left-sided carpal tunnel stenosis, and the absence of any peripheral neuropathy or ulnar neuropathy.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **3D CT Scan Post Myelogram: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

**Decision rationale:** Yes, the request for a CT myelogram of the cervical spine was medically necessary, medically appropriate, and indicated here. As noted in the MTUS Guideline in ACOEM Chapter 8, Table 8-7, page 179, both myelography and CT-myelography are scored at 4/4 in their ability to identify and define suspected anatomic defects, as were seemingly suspected here. The MTUS Guideline in ACOEM Chapter 8, page 178 also notes that imaging studies may be appropriate for applicants who are considering surgery for specific anatomic defect. Here, the applicant spine surgeon seemingly suggested on July 13, 2015 that the applicant was, in fact, actively considering/contemplating cervical spine surgery. The sentiments were echoed by those of the applicant's primary treating provider (PTP), who also suggested on various dates, including August 10, 2015, the applicant was in fact, considering cervical spine surgery. The applicant's spine surgeon seemingly reported on July 13, 2015 that earlier MRI imaging of the cervical spine and electrodiagnostic testing of the bilateral upper extremities were nondescript and failed to uncover a clear structural source for the applicant's ongoing pain complaints. Moving forward with the proposed CT myelography was, thus, indicated to better-delineate the same. Therefore, the request was medically necessary.