

<b>Case Number:</b>	CM13-0041397		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	11/04/1999
<b>Decision Date:</b>	06/10/2014	<b>UR Denial Date:</b>	09/24/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/14/2013

### 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 Maryland. 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 65 year old female who was injured in 1993-left knee/ankle; 1994-right arm; 1995-back and neck; 1999-shoulder; and 11/04/1999. The mechanism of injury is unknown. Prior treatment history has included Norco and OxyContin for pain control. Diagnostic studies reviewed include the MRI of the Lumbar spine dated 01/20/2011 demonstrates minimal central canal stenosis seen at L4-L5 and L5-S1 secondary to a 5.0 mm broad-based disc herniation. There is no associated nerve root compression seen at these levels. MRI of the cervical spine dated 12/29/2010 reveals minimal central canal stenosis seen at C6-C7 secondary to a 3.0 mm broad-based disc protrusion; minimal central canal stenosis is seen at C5-6 secondary to a 2.0 mm bulging of the disc; and mild straightening of the normal lordotic curvature. The patient's medications as of 09/12/2013 include OxyContin 60 mg bid, Zanaflex 4 mg, Imitrex nasal spray, Norco 10/325 mg, Baclofen 20 mg, and Neuro cream. Pain management re-evaluation note dated 09/12/2013 indicates the patient presents for follow-up and re-evaluation since last visit on 07/18/2013 noting increasing episodes of swelling/pain in the right hand and arm. Her daily activities are becoming more limited. There is constant low back pain, worse on the right with radicular pain bilaterally. There is radiating pain through the posterior aspect of the leg. She rated her pain since the last visit at 9/10. On examination, she continues to have baseline low back pain with cervical and thoracic pain consistent with her MRI showing multilevel disc lesion. Her low back pain is exacerbated with prolonged standing and walking. No new deficits are noted in gait or strength. She complains of neck pain that is constant and contributes to cervicogenic headaches, which is worse on the right. Positive crepitus on ROM. Decreased active range of motion of the C-spine in extension more than flexion as well as at bilateral rotation. Spasming and tenderness is noted along the paraspinal muscles in the C-spine. There is tenderness over the paraspinal muscles in the thoracic spine with limited AROM secondary to

pain as well. Radicular pain is noted in the right UE worse than the left. Grip strength is decreased with decreased sensation. Increased bilateral leg pain noted consistent with her MRI. There is decreased sensation with decreased patellar reflex. Her gait is mildly ataxic but no device is used to ambulate. Exam is unchanged since the last visit. Diagnoses are cervical spondylosis with myelopathy; lumbosacral spondylosis without myelopathy; degenerative cervical intervertebral disc; degenerative lumbar/lumbosacral intervertebral disc; degenerative thoracolumbar disc; cervicgia; pain in the thoracic spine lumbago; lumbosacral neuritis/radiculitis, NOS; spasm of muscle; and unspecified myalgia and myositis. The L-spine MRI and C-spine MRI has been requested and is pending.

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

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

#### **MRI OF THE CERVICAL SPINE: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

**Decision rationale:** As per CA MTUS/ACOEM guidelines, "unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist." As per ODG, "repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation)." In this case, this patient complains of neck pain radiating to right arm/hand. There is prior cervical MRI dated 12/29/2010 that showed central canal stenosis seen at C5-6 and C6-C7 with broad-based disc protrusion. The physical exam showed decreased ROM with crepitation, spasms and tenderness along the paraspinal muscles in the c-spine, decreased grip strength with decreased sensation. There is documentation that the patient has increased pain in the right shoulder and upper back with limitations in daily activities. The most recent progress notes report increase in pain level with average pain of 9/10. The request for an MRI of the cervical spine is medically necessary and appropriate.

#### **MRI OF THE LUMBAR SPINE: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** As per CA MTUS/ACOEM guidelines, unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. As per ODG, repeat MRI is not routinely recommended,

and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). In this case, this patient complains of lower back pain radiating to right leg. There is prior lumbar MRI dated 01/20/2011 that showed minimal central canal stenosis at L4-L5 and L5-S1 with broad-based disc herniation but no associated nerve root compression seen at these levels. The physical exam showed tenderness over the paraspinal muscles in the thoracic spine with limited AROM secondary to pain as well. Increased bilateral leg pain noted consistent with her MRI. There is decreased sensation with decreased patellar reflex. Her gait is mildly ataxic. The most recent progress notes report increase in pain level with average pain of 9/10 and limitations in daily activities. The request for an MRI of the lumbar spine is medically necessary and appropriate.