

<b>Case Number:</b>	CM13-0046287		
<b>Date Assigned:</b>	04/25/2014	<b>Date of Injury:</b>	10/26/2006
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	10/31/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/12/2013

### 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 Occupational Medicine and is licensed to practice in Iowa. 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:

This patient is a 49-year old employee with date of injury of 10/26/2006. Medical records indicate the patient is undergoing treatment for neck and low back pain with diagnoses of cervicgia and lumbago. The patient is status post bilateral knee surgery on 9/25/13. Subjective complaints include difficulty sleeping due to pain; fluctuating weight; pain and cramping in both legs and he wakes up sweating. He complains of general fatigue and loss of energy. He has anxiety and takes prescription marijuana to calm down. His back pain is an 8-9/10; constant pain in both shoulders rated 6-7/10; pain in right knee which he rates 5/10 when wearing a brace, 6/10 without the brace; pain in left knee 8-9/10 and both ankles. He describes his intermittent neck pain as 6/10. Three to four times a week he has numbness and tingling in his arms. He complains of a constant tension headache which he rates as a 9/10 without caffeine. He says he cannot do any activity without taking pain relief such as Norco or marijuana. He complains of nausea accompanied with vomiting, dizziness and loss of balance. He complains of a constant buzzing in his ears. He complains of constant muscle fatigue, dry mouth and muscle tension. He is limited in self-care, sitting, standing, walking and carrying items. He has pain putting on his shoes. He has inability to stand for very long to do things such as prepare meals. Prolonged sitting causes pain and limits his ability to drive. Objective findings include a QME Report on 10/26/2013 which noted that a previous MRI shows cervical and lumbar spine disk protrusions in April, 2008. Upon exam, his posture was normal; slow in standing from a seated position; speech pressured; he was open, histrionic and dramatic and frequently needed to be redirected. He had a brace on his right leg and his general body movements suggested agitation. His hands were shaky and had mild tremors. He had difficulty holding items. On 10/22/2013 a Cervical Spine orthopedic exam revealed tenderness to the paraspinal musculature; normal lordosis; flexion and extension at 50/50; rotation to the left and right were both at 80/80; right and left lateral bend

were both 45 degrees; no tenderness to palpation over spinous process and he had negative Hoffman's and Romberg's signs. Sensation was intact in all upper extremity dermatomes; negative heel to toe and reflexes are 2+ in biceps, triceps and brachioradialis. Lumbar spine: orthopedic exam revealed tenderness to the paraspinal musculature; normal lordosis; flexion is 60/60 and extension is 25/25; right and left lateral bend were both 25/25; no tenderness to palpation over spinous process. Treatment has consisted of bilateral knee surgery on 9/25/2013; Terocin 240 ml; Capsaicin .025%; -Methyl Salicylate 25%- Menthol 10%; Lidocaine 2.5% applying 3-4 times a day; Flurbi cream; Flurbiprofen 25%-Lidocaine 5%-Amitriptyline 4%- Gabacyclotram 180 grams-Gabapentin 10%-Cyclobenzaprine 6%-Tramadol 10%, instructing patient to apply 2-3 times a day; Genicin #90; Glucosamine Sodium; Somnicin; Melatonin 2mg-5HTP 50mg-L tryptrophan 100mg; Pyridoxine 10mg; Magnesium 50 mg for insomnia and as a muscle relaxant; Laxacin and Ducosate Sodium-Sennosides; Percocet; Norco and Prescription Marijuana. The utilization review determination was rendered on 10/31/2013 recommending non-certification of MRI of Lumbar Spine and MRI of Cervical Spine.

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

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

#### **MRI OF CERVICAL SPINE: 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, 182. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Magnetic resonance imaging (MRI).

**Decision rationale:** ACOEM states, 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. ODG is not recommended except for indications list 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. Indications for imaging MRI (magnetic resonance imaging):- Chronic neck pain (= after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present.- Neck pain with radiculopathy if severe or progressive neurologic deficit- Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present- Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present- Chronic neck pain, radiographs show bone or disc margin destruction- Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT normal- Known cervical spine trauma: equivocal or positive plain films with neurological deficit- Upper back/thoracic spine trauma with neurological deficit. The medical notes provided did not document (physical exam, objective testing, or subjective complaints) any red flags, significant worsening in symptoms or other findings suggestive of the pathologies outlined in the above guidelines. As, such the request for MRI of The Cervical Spine is not medically necessary.

**MRI OF LUMBAR SPINE:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), MRIs (magnetic resonance imaging).

**Decision rationale:** MTUS and ACOEM recommend MRI, in general, for low back pain when cauda equine, tumor, infection, or fracture are strongly suspected and plain film radiographs are negative, MRI test of choice for patients with prior back surgery ACOEM additionally recommends against MRI for low back pain before 1 month in absence of red flags. ODG states, Imaging is indicated only if they have severe progressive neurologic impairments or signs or symptoms indicating a serious or specific underlying condition, or if they are candidates for invasive interventions. Immediate imaging is recommended for patients with major risk factors for cancer, spinal infection, cauda equina syndrome, or severe or progressive neurologic deficits. Imaging after a trial of treatment is recommended for patients who have minor risk factors for cancer, inflammatory back disease, vertebral compression fracture, radiculopathy, or symptomatic spinal stenosis. Subsequent imaging should be based on new symptoms or changes in current symptoms. The medical notes provided did not document (physical exam, objective testing, or subjective complaints) any red flags, significant worsening in symptoms or other findings suggestive of the pathologies outlined in the above guidelines. As such, the request for MRI lumbar spine is not medically necessary.