

<b>Case Number:</b>	CM13-0048816		
<b>Date Assigned:</b>	01/24/2014	<b>Date of Injury:</b>	12/07/1999
<b>Decision Date:</b>	09/16/2014	<b>UR Denial Date:</b>	10/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/06/2013

### 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 Family Practice and is licensed to practice in California. 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 64-year-old female who reported an injury on 12/07/1999 after being stalked by a parent of one of her students, where she sustained head, neck, back, right rib and leg injuries. The injured worker had a history of neck and bilateral upper extremity pain with numbness and pins and needles to bilateral hands, along with lower back pain radiating into the lower extremity, causing her to drag her foot. The injured worker had diagnoses of cervical disc degeneration, cervical lumbar spondylosis, bilateral upper extremity paresthesias and left sciatica. The diagnostics included an x-ray of the cervical spine which revealed 7 cervical vertebrae with discs distended by degeneration throughout the spine from the C3 to the T1, with foraminal stenosis throughout the cervical spine. The x-ray of the lumbar spine revealed 5 lumbar vertebrae at the L5-S1 with disc degeneration, primarily the L4-5. The past treatments included physical therapy, chiropractic treatment and medication. The physical examination dated 07/30/2013 of the cervical spine revealed no tenderness present, no deformities, and no palpable spasms. The range of motion for flexion and extension of 45 degrees and rotation of 70 degrees bilaterally. Neurologic examination of the upper extremities revealed decreased sensation and pins and needles in a dysesthesias like fashion in a glove distribution involving mostly the fingertips of both hands. Otherwise there was normal sensation, motor strength and deep tendon reflexes. The examination of the thoracolumbar spine revealed no abnormalities, deformities or palpable spasm. No tenderness present. Range of motion allowed for 80 degrees of flexion at the hips and forward flexion of the ankles, extension 20 degrees with lateral bending of 30 degrees bilaterally, straight leg raise was negative. Neurological examination of the lower extremities revealed weakness of the left anterior tibialis. Otherwise there was intact motor sensation and deep tendon reflexes. No current medications at this time. No VAS provided. The treatment plan included an MRI of the lumbar and cervical region. A Request for Authorization

was not submitted with documentation. The rationale for the MRI of the cervical and lumbar spine was so that the injured worker could be further evaluated for her condition.

### **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: 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.

**Decision rationale:** The California MTUS/ACOEM indicates that MRI's 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. 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 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. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause magnetic resonance imaging for neural or other soft tissue. The clinical notes dated 07/30/13 were not evident of abnormal findings, no radiating pain to the upper or lower extremities. Motor and sensory examination revealed normal findings. The clinical notes were over a year old and were not evident that the injured worker had failed any current conservative care. The documentation was not evident of measured functional deficits. The request did not specify which level was needed. As such, the request is not medically necessary.

#### **MRI of the 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.

**Decision rationale:** The California MTUS/ACOEM indicates that and unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss the selection of an imaging test to define a potential cause magnetic resonance imaging for neural or other soft tissue, computed tomography. The clinical notes dated 07/30/13 were not evident of abnormal findings, no radiating pain to the upper or lower extremities. Motor and sensory examination revealed normal findings. The clinical notes were over a year old and were not evident that the injured worker had failed any current conservative care. The documentation was not evident of measured functional deficits. The request did not specify which region of the lumbar back was to be scanned. As such, the request is not medically necessary.