

<b>Case Number:</b>	CM13-0061534		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	05/06/2010
<b>Decision Date:</b>	04/03/2014	<b>UR Denial Date:</b>	11/07/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/05/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine, 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 physician 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 34 year old female who was injured on 05/06/2010. The patient fell from a chair which rolled with impact to the lumbosacral spine and buttocks. She experienced minimal headaches, neck pain and numbness ob both hands right after the accident. Prior treatment history has included acupuncture and chiropractic treatment. Diagnostic studies reviewed include MRI scan of the cervical spine performed 01/26/2011 revealed a C3-4 and C4-5 broad based bulge, osteophytic ridging and central protrusion resulting in moderate canal stenosis with contact and distortion of the ventral surface of the cervical cord without neuroforaminal narrowing. At C5-6 and C6-7, there was a broad based bulge present and an osteophytic ridge with left paracentral protrusion. There was a small central protrusion at C7-T1 without canal stenosis or neuroforaminal narrowing. Nerve conduction study of the upper extremity performed 09/07/2011 revealed evidence consistent with electrically mild bilateral carpal tunnel syndromes. Findings were consistent with ulnar nerve peripheral neuropathy at the left wrist level. AME dated 09/07/2011 indicated the patient experienced cervical spine pain approximately equally bilaterally. She described numbness of hands, but no upper extremity pain or pain specifically at the carpal tunnels, left great than right. There was no nocturnal exacerbation. Phalen's testing on the right was positive at 30 seconds for carpal tunnel syndrome and ulnar nerve peripheral neuropathy at Guyon's canal; Left Phalen's testing was positive at 45 seconds for carpal tunnel syndrome; bilateral paracervical tenderness was noted. She had full cervical range of motion. Biceps, triceps, and brachioradialis reflexes were symmetrical and within normal limits. She had motor deficit bilaterally of the median nerves and the right ulnar nerve; Brachial plexus stretch test for thoracic outlet syndrome was negative bilaterally. PR-2 note dated 12/09/2011 documented the patient to have complaints of ongoing neck and low back pain, rating pain as 6/10; with radiation of pain down both her legs to her calves. She was taking ketoprofen

as needed, tramadol p.r.n., and Soma as needed. She stated that these medications decreased her pain and increased her activity level. Objective findings on exam revealed cervical range of motion was limited in all directions. The patient had decreased sensation in the right C6-C7, and C8 dermatomes; Left wrist extensors and flexors were 5-/5; Biceps and brachioradialis reflexes were slightly hyperreflexic. AMA Impairment Rating note dated 03/13/2012 documented no significant clinical findings; no observed muscle guarding or spasm; no documentable neurological impairment; no documented alteration in structural integrity; no other indication of impairment related to injury or illness; no fracture of the cervical spine (0% WPI).

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

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

**MRI Cervical without contrast:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

**Decision rationale:** According to the CA MTUS guidelines, special imaging studies, may be indicated when there is an emergence of a red flag finding, evidence of tissue insult or neurological dysfunction, failure to respond to conservative care, or pending an invasive procedure. Cervical MRI is indicated in this case as the patient's neck symptoms failed to improve after a 3 to 4 week period of conservative care. Cervical MRI is certified.