

<b>Case Number:</b>	CM14-0172846		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	06/26/2001
<b>Decision Date:</b>	12/03/2014	<b>UR Denial Date:</b>	10/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/20/2014

### 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 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:

Injured worker is a male with date of injury 6/26/2001. Per primary treating physician's progress report dated 10/1/2014, the injured worker reports ongoing severe neck pain. He describes muscle spasms along the left side of his neck and shoulder blade area with popping sensation in his shoulder blade. He reports pain that radiates down his left arm. He brings a copy of an MRI performed on the cervical spine in November 2013, which reveals postoperative changes including facet arthropathy and a disk protrusion at C3-4, possibly impinging on the left C4 exiting nerve root. Also, at the C5-6 level there is facet arthropathy with disk protrusion, which appears to be possibly compromising the left exiting C6 nerve root. He states he just cannot function without the pain medication. He rates his pain a 9/10, at best 4/10 with medications and 10/10 without them. He reports 50% reduction in his pain, 50% functional improvement with activities of daily living with the medication, versus not taking them at all. He wants to be referred back to his neurosurgeon. On examination his neck range reveals limited range. He can rotate right to left about 40 degrees, flex and extend 10 degrees. Cervical compression causes neck pain that radiates into the left shoulder blade area. He reports altered sensory loss to light touch and pinprick at the left lateral forearm by comparison to the right upper extremity. Deep tendon reflexes are +1 at the biceps, triceps, and brachioradialis. Palpation reveals muscle rigidity suggesting muscle spasm in the left cervical paraspinal and cervical trapezius muscles. There is crepitus on circumduction passively in the left shoulder girdle area, particularly over the left levator scapularis and rhomboid muscle group. Diagnoses include 1) history of anterior cervical discectomy and fusion with chronic ongoing left upper extremity pain, neck pain and muscle spasms 2) history of anxiety related to neck pain and insomnia 3) history of nonindustrial medical problems including tobacco use and hyperlipidemia.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **MRI with and without contrast for the cervical spine:** Upheld

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

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

**Decision rationale:** Per the MTUS Guidelines, if physiologic evidence indicates tissue insult or nerve impairment, an MRI may be necessary. Other criteria for special studies are also not met, such as emergence of a red flag, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. The injured worker had a MRI in November 2013, which was reviewed by the requesting physician. There are no clinical changes or red flag findings to indicate that a repeat MRI is necessary. The requesting physician explains that this request is because the neurosurgeon will not see the injured worker without an MRI less than 6 months old, which by itself does not establish medical necessity within the recommendations of the MTUS Guidelines. The request for MRI with and without contrast for the cervical spine is determined to not be medically necessary.

### **EMG/NCS for the left upper extremity:** Upheld

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

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

**Decision rationale:** The MTUS Guidelines state that unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to order imaging studies if symptoms persist. When neurologic examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. EMG and NCV may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. On examination, cervical compression causes neck pain that radiates into the left shoulder blade area. The injured worker reports altered sensory loss to light touch and pinprick at the left lateral forearm by comparison to the right upper extremity. Deep tendon reflexes are +1 at the biceps, triceps, and brachioradialis. Palpation reveals muscle rigidity suggesting muscle spasm in the left cervical paraspinal and cervical trapezius muscles. There is crepitus on circumduction passively in the left shoulder girdle area, particularly over the left levator scapularis and rhomboid muscle group. A cervical MRI from November 2013 reveals postoperative changes including facet arthropathy and a disk protrusion at C3-4, possibly impinging on the left C4 exiting nerve root. Also, at the C5-6 level there is facet arthropathy with disk protrusion, which appears to be possibly compromising the left exiting C6 nerve root. The requesting physician does not provide an explanation of why

EMG/NCS of the left upper extremity is desired. The physical exam findings and prior MRI provide information should be sufficient to guide treatment in this injured worker. The request for EMG/NCS for the left upper extremity is determined to not be medically necessary.