

<b>Case Number:</b>	CM14-0203765		
<b>Date Assigned:</b>	12/16/2014	<b>Date of Injury:</b>	02/21/2012
<b>Decision Date:</b>	02/06/2015	<b>UR Denial Date:</b>	11/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/05/2014

### 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 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:

This is a 52 year old female patient who sustained a work related injury on 2/21/12 Patient sustained the injury due to slip and fall incident The current diagnoses include sprain of the cervical, thoracic and lumbar region Per the doctor's note dated 11/24/14, patient has complaints of chronic neck pain with burning and numbness in hands and forearm Physical examination of the cervical region revealed limited range of motion without neurological deficits and snapping left scapula The current medication list was not specified in the records provided Diagnostic imaging reports were not specified in the records provided. The patient's surgical history include anterior cervical fusion and discectomy and fusion at C4-5, C5-6 and C6-7 Any operative/ or procedure note was not specified in the records provided Other therapy done for this injury was not specified in the records provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI without contrast, cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back (updated 11/18/14), Magnetic resonance imaging (MRI).

**Decision rationale:** Per the ACOEM chapter 8 guidelines cited below "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." Per the ACOEM chapter 8 guidelines cited below recommend "MRI or CT to evaluate red-flag diagnoses as above, MRI or CT to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. If no improvement after 1 month bone scans if tumor or infection possible, not recommended: Imaging before 4 to 6 weeks in absence of red flags." Physical examination of the cervical region revealed no neurological deficits. Patient does not have any severe or progressive neurological deficits that are specified in the records provided. The findings suggestive of tumor, infection, fracture, neuro compression, or other red flags were not specified in the records provided. A report of a recent cervical spine plain radiograph was also not specified in the records provided. The details of PT or other types of therapy done since the date of injury were not specified in the records provided. Previous PT notes were not specified in the records provided. The records submitted contain no accompanying current PT evaluation for this patient. A plan for an invasive procedure of the cervical spine was not specified in the records provided. Furthermore, documentation of response to other conservative measures such as oral pharmacotherapy in conjunction with rehabilitation efforts was not provided in the medical records submitted. The request for MRI without contrast, cervical spine is not fully established for this patient.

**MRI with and without contrast, lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Workers' Comp., online Edition, Chapter: Low Back (updated 11/21/14), MRIs (magnetic resonance imaging).

**Decision rationale:** Per the ACOEM low back guidelines cited below "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 with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures)." A detailed physical examination of the lumbar spine was not specified in the records provided. Any significant functional deficits of the lumbar spine that would require MRI was not specified in the records provided. Patient did not have any evidence of severe or progressive neurologic deficits that are specified in the records provided. Any finding indicating red flag pathologies were not specified in the records provided. The history or physical exam findings did not indicate pathology including cancer,

infection, or other red flags. The details of PT or other types of therapy done since the date of injury were not specified in the records provided. The records submitted contain no accompanying current PT evaluation for this patient. A detailed response to complete course of conservative therapy including PT visits was not specified in the records provided. Previous PT visit notes were not specified in the records provided. A plan for an invasive procedure of the lumbar spine was not specified in the records provided. Furthermore, documentation of response to other conservative measures such as oral pharmacotherapy in conjunction with rehabilitation efforts was not provided in the medical records submitted. A recent lumbar spine X-ray report is not specified in the records provided. The medical necessity of the MRI with and without contrast, lumbar spine is not fully established for this patient.

**CT scan of chest and scapula:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (updated 10/31/14), Computed tomography (CT).

**Decision rationale:** According to ACOEM guidelines cited below, "for most patients, 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: Emergence of a red flag; e.g., indications of intra abdominal or cardiac problems presenting as shoulder problems; -Physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon); Failure to progress in a strengthening program intended to avoid surgery.; Clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment)." In addition as per cited guidelines "Indications for imaging -- Computed tomography (CT):- Suspected tears of labrum - Plain x-ray, then CT - Full thickness rotator cuff tear or SLAP tear - clinically obvious or suspected - Plain x-ray and ultrasound, then MRI or CT- Recurrent instability - CT arthrogram (Newberg, 2000)- In proximal humeral fractures when the proximal humerus and the shoulder joint are not presented with sufficient X-ray-quality to establish a treatment plan" Any of these indications that would require a computed tomography (CT) scan of the chest and scapula were not specified in the records provided. Any physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon) were not specified in the records provided. A detailed physical examination of the chest and scapula was not specified in the records provided. The records provided did not indicate that surgical interventions were being considered. The records provided also did not specify recent diagnostic imaging reports of the X-rays of the chest and scapula. The details of PT or other types of therapy done since the date of injury were not specified in the records provided. The records submitted contain no accompanying current PT evaluation for this patient. Detailed response to previous conservative therapy was not specified in the records provided. Previous conservative therapy notes were not

specified in the records provided. Furthermore, documentation of response to other conservative measures such as oral pharmacotherapy in conjunction with rehabilitation efforts was not provided in the medical records submitted. The history or physical examination findings do not indicate pathology including cancer, infection, or other red flags. The medical necessity of the request for CT scan of chest and scapula is not fully established in this patient.