

<b>Case Number:</b>	CM15-0100565		
<b>Date Assigned:</b>	08/14/2015	<b>Date of Injury:</b>	08/03/2012
<b>Decision Date:</b>	09/14/2015	<b>UR Denial Date:</b>	05/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/26/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 male who sustained an industrial injury on August 03, 2012. The worker was employed as a maintenance man. The accident described while working climbing onto a piece of moving equipment a co-worker proceeded to move the machinery without the worker being seated and he resulted with injury. A neurosurgical follow up dated April 23, 2015 reported subjective complaint of stiffness and tightness in the neck accompanied by a constant everyday headache in the orbital region. He is working a modified work duty. He states taking 6 tablets of Norco daily and Ibuprofen twice daily which bring down the pain level to a 4 in intensity out of 10. The following diagnoses were applied: status post C3-4 and C6-7, C7-T1 anterior cervical fusion; lower back pain with radiculopathy; left carpal tunnel syndrome confirmed on left upper extremity nerve conduction testing; shoulder bursitis, left; chronic obstructive pulmonary disease with a forty plus pack history of smoking, and Hepatitis. The plan of care noted continuing and prescribing Norco 10mg 325mg 1-2 tablets TID #180. There is recommendation for surgical consultation regarding right shoulder, along with a radiographic study of the spine including flexion and extension. He is prescribed a modified work duty. A neurosurgical follow up dated March 19, 2015 reported subjective complaint of stiff neck and headache.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar spine x-rays: 5 view with flexion and extension: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Radiography, Flexion/extension imaging studies.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back-Lumbar & Thoracic Chapter, under Flexion/Extension Imaging Studies.

**Decision rationale:** The patient was injured on 08/03/12 and presents with low back pain, neck pain, and headaches. The request is for LUMBAR SPINE X-RAYS 5 VIEW WITH FLEXION AND EXTENSION. The RFA is dated 05/04/15 and the patient is on modified work duty up to 40 hours a week. Review of the reports provided do not indicate if the patient had a prior x-ray of the lumbar spine. ODG guidelines, Low Back-Lumbar & Thoracic Chapter, under Flexion/Extension Imaging Studies, state the following: Not recommended as a primary criteria for range of motion. An inclinometer is the preferred device for obtaining accurate, reproducible measurements. See Range of motion (ROM); Flexibility. For spinal instability, may be a criteria prior to fusion, for example in evaluating symptomatic spondylolisthesis when there is consideration for surgery. The reason for the request is not provided and there are no objective findings provided for the lumbar spine. The patient is diagnosed with status post C3-4 and C6-7, C7-T1 anterior cervical fusion; lower back pain with radiculopathy; left carpal tunnel syndrome confirmed on left upper extremity nerve conduction testing; shoulder bursitis, left; chronic obstructive pulmonary disease with a forty plus pack history of smoking, and Hepatitis. The 03/28/15 QME report refers to a lumbar spine MRI the patient had (date of MRI not provided) which revealed chronic low back pain, multilevel degeneration, stenosis, S1 root cyst, and a L3-4 annular fissure. In this case, there is no discussion regarding evaluation of symptomatic spondylolisthesis, lumbar instability and impending fusion surgery, as required by ODG for flexion/extension x-rays. Therefore, the request IS NOT medically necessary.