| Case Number: | CM15-0143402 | | |
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| Date Assigned: | 08/04/2015 | Date of Injury: | 04/02/2013 |
| Decision Date: | 09/23/2015 | UR Denial Date: | 06/29/2015 |
| Priority: | Standard | Application Received: | 07/23/2015 |

## 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 30 year old female, who sustained an industrial injury on 04-02-2013, secondary to being physical assaulted. On provider visit dated 06-10-2015 the injured worker has reported chronic back pain. On examination, the loss of normal lordosis was not but was able to demonstrate pelvic tilt. Ambulation was noted as somewhat widened base-gait. The diagnoses have included chronic back pain, including cervical, thoracic and lumbar. Treatment to date has included medication. The provider requested MRI of the thoracic spine, MRI of cervical spine, MRI of the lumbar spine, electromyogram-nerve conduction velocity of bilateral upper extremities, functional restoration program consultation for total spine and SI belt for total spine.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of the thoracic spine:** Upheld

**Claims Administrator 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).

**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 and Thoracic Chapter, under MRI's.

**Decision rationale:** The patient presents with chronic back pain. The request is for MRI OF THE THORACIC SPINE. The request for authorization is dated 06/22/15. X-ray of the cervical spine, 04/07/15, shows no cervical compression fracture of spondylolisthesis. Physical examination of the cervical spine reveals generalized tenderness extending from the upper to the lower areas to the cervical spine. However, there are no palpable masses and there is no paravertebral tenderness. Negative Spurling's, bilaterally. There is no decrease in strength or sensation to the upper extremities. DTRs are symmetrical. Exam of thoracic spine reveals mild paravertebral tenderness at approximately T5, T6, and T7. There are no palpable masses. Exam of lumbar spine reveals no tenderness to palpation of the paravertebral musculature. Nor is there lumbar tenderness to the paraspinous areas. Negative straight leg raises, bilaterally. DTRs are symmetrical. There is no decrease in strength or sensation to the lower extremities. Ambulation is a somewhat widened-base gait. The patient will continue her physical therapy sessions and home exercise program. She can also continue conservative modalities for treatment of pain such as positioning, hear, or cold applications. Patient's medication includes Amitriptyline. Per progress report dated 06/10/15, the patient may continue her normal duties. ODG, Low Back Lumbar and Thoracic Chapter, MRI's, states, "Recommended for indications below. MRI's are test of choice for patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy, not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation)." Per progress report dated 06/10/15, treater's reason for the request is "the request from [redacted] who needs additional data to complete her report." Review of provided medical records do not show that the patient has had a prior MRI of the Thoracic Spine. Physical examination of thoracic spine reveals mild paravertebral tenderness at approximately T5, T6, and T7. There are no palpable masses. In this case, there are no signs of neurologic deficit. ODG requires neurologic signs and symptoms for an MRI. The patient does not present with any red flags, significant exam findings demonstrating neurologic deficit to consider an MRI. Therefore, the request is not medically necessary.

**MRI of the cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back.

**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 (Acute & Chronic) Chapter, under MRIs.

**Decision rationale:** The patient presents with chronic back pain. The request is for MRI OF THE CERVICAL SPINE. The request for authorization is dated 06/22/15. X-ray of the cervical

spine, 04/07/15, shows no cervical compression fracture of spondylolisthesis. Physical examination of the cervical spine reveals generalized tenderness extending from the upper to the lower areas to the cervical spine. However, there are no palpable masses and there is no paravertebral tenderness. Negative Spurling's, bilaterally. There is no decrease in strength or sensation to the upper extremities. DTRs are symmetrical. Exam of thoracic spine reveals mild paravertebral tenderness at approximately T5, T6, and T7. There are no palpable masses. Exam of lumbar spine reveals no tenderness to palpation of the paravertebral musculature. Nor is there lumbar tenderness to the paraspinous areas. Negative straight leg raises, bilaterally. DTRs are symmetrical. There is no decrease in strength or sensation to the lower extremities. Ambulation is a somewhat widened-base gait. The patient will continue her physical therapy sessions and home exercise program. She can also continue conservative modalities for treatment of pain such as positioning, hear, or cold applications. Patient's medication includes Amitriptyline. Per progress report dated 06/10/15, the patient may continue her normal duties. ODG-TWC Guidelines, Low Back & Lumbar & Thoracic (Acute & Chronic) Chapter, under MRIs (magnetic resonance imaging) Section states, "for uncomplicated back pain MRIs are recommended for radiculopathy following at least one month of conservative treatment." ODG guidelines further state the following regarding MRI's, "Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation)." ACOEM Guidelines, chapter 8, page 177 and 178, state, "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." ODG Guidelines, chapter 'Neck and Upper Back (Acute & Chronic)' and topic 'Magnetic resonance imaging (MRI)', have the following criteria for cervical MRI: (1) Chronic neck pain (after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present. (2) Neck pain with radiculopathy if severe or progressive neurologic deficit. (3) Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present. (4) Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present. (5) Chronic neck pain, radiographs show bone or disc margin destruction. (6) Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal". (7) Known cervical spine trauma: equivocal or positive plain films with neurological deficit. (8) Upper back/thoracic spine trauma with neurological deficit. Per progress report dated 06/10/15, treater's reason for the request is "the request from [redacted] who needs additional data to complete her report." Review of provided medical records do not show that the patient has had a prior MRI of the Cervical Spine. Physical examination of the cervical spine reveals generalized tenderness extending from the upper to the lower areas to the cervical spine. However, there are no palpable masses and there is no paravertebral tenderness. Negative Spurling's, bilaterally. There is no decrease in strength or sensation to the upper extremities. DTRs are symmetrical. However, ODG guidelines require neurologic signs and symptoms for an MRI. The patient does not present with any red flags, significant exam findings demonstrating neurologic deficit to consider an MRI. Therefore, 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 Page(s): 308-310.

**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 (Acute & Chronic) Chapter, under MRIs.

**Decision rationale:** The patient presents with chronic back pain. The request is for MRI OF THE LUMBAR SPINE. The request for authorization is dated 06/22/15. X-ray of the cervical spine, 04/07/15, shows no cervical compression fracture of spondylolisthesis. Physical examination of the cervical spine reveals generalized tenderness extending from the upper to the lower areas to the cervical spine. However, there are no palpable masses and there is no paravertebral tenderness. Negative Spurling's, bilaterally. There is no decrease in strength or sensation to the upper extremities. DTRs are symmetrical. Exam of thoracic spine reveals mild paravertebral tenderness at approximately T5, T6, and T7. There are no palpable masses. Exam of lumbar spine reveals no tenderness to palpation of the paravertebral musculature. Nor is there lumbar tenderness to the paraspinous areas. Negative straight leg raises, bilaterally. DTRs are symmetrical. There is no decrease in strength or sensation to the lower extremities. Ambulation is a somewhat widened-base gait. The patient will continue her physical therapy sessions and home exercise program. She can also continue conservative modalities for treatment of pain such as positioning, hear, or cold applications. Patient's medication includes Amitriptyline. Per progress report dated 06/10/15, the patient may continue her normal duties. ODG-TWC Guidelines, Low Back & Lumbar & Thoracic (Acute & Chronic) Chapter, under MRIs (magnetic resonance imaging) Section states, "for uncomplicated back pain MRIs are recommended for radiculopathy following at least one month of conservative treatment." ODG guidelines further state the following regarding MRI's, "Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation)." Per progress report dated 06/10/15, treater's reason for the request is "the request from [redacted] who needs additional data to complete her report." Review of provided medical records do not show that the patient has had a prior MRI of the Lumbar Spine. Physical examination of lumbar spine reveals no tenderness to palpation of the paravertebral musculature. Nor is there lumbar tenderness to the paraspinous areas. Negative straight leg raises, bilaterally. DTRs are symmetrical. There is no decrease in strength or sensation to the lower extremities. In this case, there are no signs of neurologic deficit. ODG requires neurologic signs and symptoms for an MRI. The patient does not present with any red flags, significant exam findings demonstrating neurologic deficit to consider an MRI. Therefore, the request is not medically necessary.

**EMG/NCV of bilateral upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262.

**Decision rationale:** The patient presents with chronic back pain. The request is for EMG/NCV OF BILATERAL UPPER EXTREMITIES. The request for authorization is dated 06/22/15. X-ray of the cervical spine, 04/07/15, shows no cervical compression fracture of spondylolisthesis. Physical examination of the cervical spine reveals generalized tenderness extending from the upper to the lower areas to the cervical spine. However, there are no palpable masses and there is no paravertebral tenderness. Negative Spurling's, bilaterally. There is no decrease in strength or sensation to the upper extremities. DTRs are symmetrical. Exam of thoracic spine reveals mild paravertebral tenderness at approximately T5, T6, and T7. There are no palpable masses. Exam of lumbar spine reveals no tenderness to palpation of the paravertebral musculature. Nor is there lumbar tenderness to the paraspinous areas. Negative straight leg raises, bilaterally. DTRs are symmetrical. There is no decrease in strength or sensation to the lower extremities. Ambulation is a somewhat widened-base gait. The patient will continue her physical therapy sessions and home exercise program. She can also continue conservative modalities for treatment of pain such as positioning, hear, or cold applications. Patient's medication includes Amitriptyline. Per progress report dated 06/10/15, the patient may continue her normal duties. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, page 260-262 states: "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist." Per progress report dated 06/10/15, treater's reason for the request is "again, as per [redacted] for the medical legal report. In this case, there is no evidence that the patient has had prior Bilateral Upper extremity EMG/NCV studies done. The patient continues with chronic cervical spine pain. Physical examination of the cervical spine reveals generalized tenderness extending from the upper to the lower areas to the cervical spine. However, there are no palpable masses and there is no paravertebral tenderness. Negative Spurling's, bilaterally. There is no decrease in strength or sensation to the upper extremities. DTRs are symmetrical. In this case, treater does not discuss or document any physical examination findings or diagnosis to indicate an EMG/NCV of Bilateral Upper Extremities. Therefore, the request is not medically necessary.

**Functional restoration program consultation for total spine:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 31-32. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition, 2004, Chapter 7, Independent Medical Examinations and Consultations, pg. 127, 156.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs Page(s): 30 to 32.

**Decision rationale:** The patient presents with chronic back pain. The request is for FUNCTIONAL RESTORATION PROGRAM CONSULTATION FOR TOTAL SPINE. The request for authorization is dated 06/22/15. X-ray of the cervical spine, 04/07/15, shows no cervical compression fracture of spondylolisthesis. Physical examination of the cervical spine reveals generalized tenderness extending from the upper to the lower areas to the cervical spine. However, there are no palpable masses and there is no paravertebral tenderness.

Negative Spurling's, bilaterally. There is no decrease in strength or sensation to the upper extremities. DTRs are symmetrical. Exam of thoracic spine reveals mild paravertebral tenderness at approximately T5, T6, and T7. There are no palpable masses. Exam of lumbar spine reveals no tenderness to palpation of the paravertebral musculature. Nor is there lumbar tenderness to the paraspinous areas. Negative straight leg raises, bilaterally. DTRs are symmetrical. There is no decrease in strength or sensation to the lower extremities. Ambulation is a somewhat widened- base gait. The patient will continue her physical therapy sessions and home exercise program. She can also continue conservative modalities for treatment of pain such as positioning, hear, or cold applications. Patient's medication includes Amitriptyline. Per progress report dated 06/10/15, the patient may continue her normal duties. MTUS Guidelines page 30 to 32 recommends Functional Restoration Programs when all of the following criteria are met including: (1) Adequate and thorough evaluation has been made; (2) previous method of treating chronic pain had been unsuccessful; (3) significant loss of ability to function independently resulting in chronic pain; (4) not a candidate for surgery; (5) exhibits motivation to change; (6) negative predictor of success has been addressed, etc. The supporting document for FRP is based on Chronic Pain Medical Treatment Guidelines. The guidelines specifically state that FRP is recommended for patients with chronic disabling, occupational and musculoskeletal condition. MTUS guidelines do recommend functional restoration programs. There are 6 criteria that must be met to be recommended for FRP. Per progress report dated, 06/10/15, treater's reason for the request is "there was a recommendation for multi-disciplinary functional restoration program by [redacted]." Given the patient's persistent, chronic symptoms, and support from MTUS for Functional Restoration Program, a Consultation to determine the patient's candidacy is reasonable. Therefore, the request is medically necessary.

**SI belt for total 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 (ODG).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

**Decision rationale:** The patient presents with chronic back pain. The request is for SI BELT FOR TOTAL SPINE. The request for authorization is dated 06/22/15. X-ray of the cervical spine, 04/07/15, shows no cervical compression fracture of spondylolisthesis. Physical examination of the cervical spine reveals generalized tenderness extending from the upper to the lower areas to the cervical spine. However, there are no palpable masses and there is no paravertebral tenderness. Negative Spurling's, bilaterally. There is no decrease in strength or sensation to the upper extremities. DTRs are symmetrical. Exam of thoracic spine reveals mild paravertebral tenderness at approximately T5, T6, and T7. There are no palpable masses. Exam of lumbar spine reveals no tenderness to palpation of the paravertebral musculature. Nor is there lumbar tenderness to the paraspinous areas. Negative straight leg raises, bilaterally. DTRs are symmetrical. There is no decrease in strength or sensation to the lower extremities. Ambulation is a somewhat widened-base gait. The patient will continue her physical therapy sessions and home exercise program. She can also continue conservative modalities for treatment of pain

such as positioning, hear, or cold applications. Patient's medication includes Amitriptyline. Per progress report dated 06/10/15, the patient may continue her normal duties. ACOEM Guidelines page 301 on lumbar bracing states, "lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." ACOEM guidelines further state that they are not recommended for treatment, but possibly used for prevention if the patient is working. ODG Low Back & Lumbar & Thoracic Chapter, lumbar supports topic, states, "Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option)." For post-operative bracing, ODG states, "Under study, but given the lack of evidence supporting the use of these devices, a standard brace would be preferred over a custom post-op brace, if any, depending on the experience and expertise of the treating physician." Per progress report dated 06/10/15, treater's reason for the request is "[redacted] has recommended that the patient wear an SI belt." However, guidelines recommend lumbar bracing only for the acute phase of symptom relief, compression fractures, treatment of spondylolisthesis and documented instability. No evidence of aforementioned conditions is provided for this patient. There is no evidence of recent back surgery, either. For non-specific low back pain, there is very low quality evidence, and ACOEM guidelines do not support the use of a back brace for chronic pain. Therefore, the request is not medically necessary.