

<b>Case Number:</b>	CM15-0188685		
<b>Date Assigned:</b>	09/30/2015	<b>Date of Injury:</b>	01/14/2008
<b>Decision Date:</b>	11/13/2015	<b>UR Denial Date:</b>	08/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/24/2015

### 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 53 year old female who sustained an industrial injury on 1-14-2008. A review of medical records indicated the injured worker is being treated for cervical pain, disc disorder cervical, cervical radiculopathy, carpal tunnel syndrome, and lateral epicondylitis. Medical records dated 8-20-2015 noted pain was unchanged since last visit and reports pain without medication a 3 out of 10. Physical examination noted tenderness to palpation over the lateral epicondyle. There was tenderness to palpation over the metacarpophalangeal joint of the little finger. Inspection of the hand revealed slight atrophy of the thenar eminence. Treatment has included medications, right elbow and right hand steroid injection, and cervical spinal 2 level fusion surgery. Utilization review dated 8-25-2015 noncertified X-rays of cervical spine with lateral flexion and extension views.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**X rays of cervical spine with lateral flexion and extension views:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation, Neck and Upper Back Procedure Summary Online Version last updated 08/25/2015.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter under Radiography (X-rays).

**Decision rationale:** The 53 year old patient presents with cervical pain, rated at 3/10 without medications, cervical disc disorder, cervical radiculopathy, carpal tunnel syndrome, and lateral epicondylitis, as per progress report dated 08/20/15. The request is for X rays of the cervical spine with lateral flexion and extension views. There is no RFA for this case, and the patient's date of injury is 01/14/08. Medications, as per progress report dated 08/20/15, included Trazodone, Voltaren gel, Lidoderm patch, Acyclovir, Celebrex, Neurontin, Venlafaxine, Temazepam, Retin, Levothyroid, Flonase, Estradiol and Famotidine. Diagnoses, as per progress report dated 08/06/15, included repetitive strain injury of bilateral upper extremities; bilateral carpal tunnel syndrome, status post carpal tunnel surgery; bilateral lateral epicondylitis; possible flexor tendonitis; cervical strain with degenerative changes and neural foraminal narrowing at C6-7; and swelling at the base of right fourth and fifth fingers, possible bipartite sesmoid bone. Diagnoses, as per progress report dated 04/27/15, included acquired spondylolisthesis, brachial neuritis, cervical spinal stenosis, and cervical intervertebral disc displacement. The patient is working full time, as per progress report dated 08/20/15. ACOEM Guidelines, chapter 8, Neck and Upper Back Complaints 2004, Special Studies, page 330 states "unequivocal objective findings that identifies specific nerve compromise on the neurological examination is sufficient evidence to warrant imaging in patients who did not respond well to treatment and who would consider surgery as an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study." ODG-TWC, Neck and Upper Back Chapter under Radiography (X-rays) states that cervical x-rays are "not recommended except for indications below. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, and have no neurologic findings, do not need imaging. Patients who do not fall into this category should have a three-view cervical radiographic series followed by computed tomography (CT). In determining whether or not the patient has ligamentous instability, magnetic resonance imaging (MRI) is the procedure of choice, but MRI should be reserved for patients who have clear-cut neurologic findings and those suspected of ligamentous instability. (Anderson, 2000) (ACR, 2002) Initial studies may be warranted only when potentially serious underlying conditions are suspected like fracture or neurologic deficit, cancer, infection or tumor." In this case, a request for "anniversary radiographs for October" is noted in progress report dated 04/27/15 from the spinal surgeon. The patient underwent C5-6 and C6-7 discectomy and fusion, as per operative report dated 10/01/13. Although the treater does not provide any other explanation, the request may be related to the "anniversary" of this surgery. Radiographs of the cervical spine, dated 12/23/13, revealed solidly consolidating fusions from C5 to C7. X-ray of the cervical spine, dated 07/08/14, revealed straightening of the cervical lordosis, and good alignment with stability maintained on flexion and extension. As per progress report dated 01/05/15, radiographs of the cervical spine revealed solid C5-6 fusion. Physical examination of the cervical spine revealed mild tenderness along diminished sensation to pinprick in both hands, as per neurology progress report dated 08/06/15. The primary care physician states that the x-rays will be needed prior to visiting the spinal surgeon "to rule out instability". ODG and ACOEM guidelines, however, support the use of x-rays only in patients

with neurologic deficits. Furthermore, the patient had X-rays with flex/ext views from 1/5/15 that showed solid fusion and no instability. There are no new injuries to consider. The request is not medically necessary.