

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM15-0197129 |                              |            |
| <b>Date Assigned:</b> | 10/14/2015   | <b>Date of Injury:</b>       | 10/18/2013 |
| <b>Decision Date:</b> | 12/03/2015   | <b>UR Denial Date:</b>       | 09/15/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 10/06/2015 |

### 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, Hawaii  
 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 64 year old female, who sustained an industrial-work injury on 10-18-13. A review of the medical records indicates that the injured worker is undergoing treatment for cervical spondylosis, low back pain, cervical spine strain, right shoulder strain, right wrist strain and lumbar spine strain. Medical records dated 8-27-15 and 4-2-15 indicate that the injured worker complains of neck pain that travels to the right shoulder area with headaches. She reports constant right shoulder pain, intermittent moderate right hand and wrist pain and constant moderate low back pain. The physician notes that there are no radicular complaints. Treatment to date has included pain medication, diagnostics, Psyche care, Cymbalta, Used Prozac, acupuncture at least 8 sessions, orthopedic care and other modalities. Magnetic resonance imaging (MRI) of the cervical spine dated 3-31-15 reveals multi-level disc height loss, disc osteophyte complexes, and multi-level osteophytosis with mild bilateral neural foraminal narrowing. X-rays of the cervical spine dated 10-23-13 the physician indicates that there are disc space narrowing, moderate degenerative changes. The electromyography (EMG)-nerve conduction velocity studies (NCV) dated 3-31-14 the physician indicates that there is moderate right carpal tunnel syndrome and no evidence of cervical radiculopathy. Per the treating physician report dated 8-27-15 the work status is permanent and stationary. The physical exam dated 8-27-15 reveals cervical tenderness, positive cervical distraction test, muscle spasms are noted and restricted cervical range of motion due to complaints of pain. The right shoulder exam reveals tenderness, restricted range of motion due to pain and rotator cuff weakness is noted. The right hand and wrist exam reveals tenderness, weakness in grip strength, and restricted range of

motion due to discomfort. The lumbar exam reveals tenderness about the paralumbar muscle, over the lumbar facets and right greater sciatic notch with muscle spasms. The straight leg raise is positive on the left and Lasegue's sign is positive on the left. The physician indicates that he would like to better assess the root of the patient's complaints and recommends Magnetic Resonance Imaging (MRI) of cervical and lumbar spine and physical therapy. The request for authorization date was 9-8-15 and requested services included Magnetic resonance imaging (MRI) of the cervical spine, Magnetic resonance imaging (MRI) of the lumbar spine and Physical therapy 2 times a week for 4 weeks for the neck, right shoulder, right wrist and lumbar spine. The original Utilization review dated 9-15-15 non-certified the request for Magnetic resonance imaging (MRI) of the cervical spine, Magnetic resonance imaging (MRI) of the lumbar spine and Physical therapy 2 times a week for 4 weeks for the neck, right shoulder, right wrist and lumbar spine.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Magnetic resonance imaging (MRI) of the cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Neck chapter, Magnetic resonance imaging (MRI).

**Decision rationale:** The records indicate the patient has chronic neck, right shoulder, right wrist, and low back pain dating back to a 10/18/13 date of injury. The current request for consideration is an MRI of the cervical spine. The attending physician report dated 8/27/15, page (150b), and states "I would like to request authorization for updated MRI study of the cervical and lumbar spine to better assess the root of the patients complaints." ODG under the neck and upper back chapter on MRI states, "MRI imaging studies are valuable when physiologic evidence indicates tissue insult or nerve impairment or potentially serious conditions are suspected like tumor infection and fracture or for a clarification of anatomy prior to surgery." The ODG guidelines for repeat cervical MRI states, "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)." In this case, the medical records indicate that a previous MRI was completed as recent as 3/31/15, which demonstrated multilevel degenerative disc disease. The physical examination, which was completed on 8/27/15, offers no evidence of focal neurological deficit. The subjective complaints are not consistent with radiculopathy. The patient does not meet the criteria for an MRI and certainly not for a repeat MRI, based solely on ongoing neck pain. The current request is not medically necessary.

**Magnetic resonance imaging (MRI) of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low back Chapter, Magnetic resonance imaging (MRI).

**Decision rationale:** The records indicate the patient has chronic neck, right shoulder, right wrist, and low back pain dating back to a 10/18/13 date of injury. The current request for consideration is an MRI of the lumbar spine. The attending physician report dated 8/27/15, page (150b), and states "I would like to request authorization for updated MRI study of the cervical and lumbar spine to better assess the root of the patients complaints." The MTUS guidelines do not address lumbar spine MRI scans. The ODG guidelines lumbar chapter recommends MRI scans for patients with lower back pain with radiculopathy, suspicion of cancer, infection and other red flags. The attending physician in this case has not presented any evidence of any progressive neurological deficit or red flags. There is no report of any recent spine trauma or myelopathy, there is only reports of ongoing low back pain. There are no current neurologic deficits, no red flags and therefore the request is not consistent with ODG criteria for MRI scans of the lumbar spine. The request for lumbar MRI is not medically necessary.

**Physical therapy 2 times a week for 4 weeks for the neck, right shoulder, right wrist and lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**Decision rationale:** The records indicate the patient has chronic neck, right shoulder, right wrist, and low back pain dating back to a 10/18/13 date of injury. The current request for consideration is for physical therapy 2 x a week for 4 weeks for the neck, right shoulder, right wrist and lumbar spine. The attending physician report dated 8/27/15, page (150b), states "I would like to request authorization for the patient to undergo physical therapy at a rate of two times per week for four weeks. He offers no other discussion for the request. CA MTUS does recommend physical therapy for chronic pain involving the cervical and lumbar spine, the shoulder and for the wrist. The CA MTUS recommends physical therapy at a decreasing frequency with a transition into independent home-based exercise. The Physical medicine guidelines recommend for Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. In this case, the patient became permanent and stationary on 12/31/14. Records indicate the patient has not been consistent with home-based exercise. The attending physician offers no discussion on a new injury or for an acute exacerbation of her chronic condition. The medical records indicate the patient has been provided with extensive physical therapy in the past. The patient should be well versed in a home-based exercise program. The available medical records do not establish medical necessity for the recent request of physical therapy at two visits per week for 4 weeks.