

<b>Case Number:</b>	CM14-0181029		
<b>Date Assigned:</b>	11/05/2014	<b>Date of Injury:</b>	10/29/2008
<b>Decision Date:</b>	12/09/2014	<b>UR Denial Date:</b>	10/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/31/2014

### 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 Occupational Medicine 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:

Injured worker is a male with date of injury 10/29/2008. Per neurosurgery progress note dated 10/10/2014, the injured worker complains of cervical and lumbar stenosis. He has a six month history of generalized weakness in the lower extremities. He has numbness in the feet. He denies any specific pain. He does have right carpal tunnel syndrome. On examination the low back is soft and not tender. Straight leg raise is negative. Neck is soft with minimal tenderness to palpation and adequate range of motion. Neurological exam is normal. Diagnoses include 1) cervical spondylosis without myelopathy 2) thoracic spondylosis without myelopathy 3) lumbosacral spondylosis without myelopathy 4) lumbar stenosis with atypical features which suggests the lumbar stenosis is not the source of his lower extremity weakness 5) possible peripheral neuropathy 6) possible myelopathy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** Per the MTUS Guidelines, if physiologic evidence indicates tissue insult or nerve impairment, an MRI may be necessary. Other criteria for special studies are also not met, such as emergence of a red flag; failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines.

**MRI thoracic spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** Per the MTUS Guidelines, if physiologic evidence indicates tissue insult or nerve impairment, an MRI may be necessary. Other criteria for special studies are also not met, such as emergence of a red flag; failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines. The request for MRI thoracic spine is determined to not be medically necessary.

**Physical therapy lumbar:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** The MTUS Guidelines recommend physical therapy focused on active therapy to restore flexibility, strength, endurance, function, range of motion and alleviate discomfort. The MTUS Guidelines support physical therapy that is providing a documented benefit. Physical therapy should be provided at a decreasing frequency (from up to 3 visits per week to 1 or less) as the guided therapy becomes replaced by a self-directed home exercise program. The physical medicine guidelines recommend myalgia and myositis, unspecified; receive 9-10 visits over 8 weeks. The injured worker is diagnosed with lumbosacral spondylosis without myelopathy and lumbar stenosis with atypical features. The injured worker does not report any current low back complaints, examination findings of the low back and lumbar spine are negative or normal, and there are no functional deficits noted. The injured worker is also noted have been injury six years ago, and there are no reports of prior physical therapy to include total number of sessions and benefit as a result of physical therapy. There is no report regarding a home exercise program for the injured worker. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines. The request for physical therapy lumbar is determined to not be medically necessary.