

<b>Case Number:</b>	CM14-0215716		
<b>Date Assigned:</b>	01/05/2015	<b>Date of Injury:</b>	01/07/2000
<b>Decision Date:</b>	03/03/2015	<b>UR Denial Date:</b>	11/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/23/2014

### 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. 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: Pennsylvania, Ohio, 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 46 year female with a date of birth of [REDACTED]. Results of the injury included lower back, psyche, urological, and cervical problems. Diagnosis include cervical herniated nucleus pulposus and lumbar herniated nucleus pulposus. Treatment included Continuous bladder techniques, pain management therapy, cymbalta, clonazepam, cognitive behavioral intervention, tizanidine, and topiramate. Per the Utilization review form Magnetic Resonance Imaging (MRI) of the lumbar spine dated September 29, 2009 showed status post L4-5 laminectomy with L4 and S1 bilateral posterior fusion, bilateral L5-S1 and right L4-5 and right L4-5 and L3-4 foraminal stenosis, degenerative disc disease at L3-4 and intervertebral disc spacers at L4-5 and L5-S1. Magnetic Resonance Imaging of the cervical spine of unknown date showed significant neural compression of her C5-6 spinal cord due to a disk herniation at C5-6 and a contralateral disk herniation centrally at C4-5. The C5-6 disk is an extrusion on the patients right hand side with compression of the spinal cord, and that at C4-C5 there is an extrusion with effacement of the spinal cord on the left hand side. X-rays of the cervical spine dated August 20, 2013 showed status post anterior fusion with no evidence of acute complications. Progress report dated September 8, 2014 showed the injured worker to have increased pain and discomfort. Cervical spine showed pain with range of motion and a positive Spurlings test with spasms. Lumbar spine showed positive pain with flexion and extension, positive radiculopathy, and paraspinal spasm. Treatment plan dated November 21, 2014 was for Magnetic Resonance Imaging of the lumbar and cervical spine, Physical therapy for the lumbar and cervical spine, and a wheel chair. Utilization Review form dated November 28, 2014 non certified cervical spine MRI,

lumbar MRI, physical therapy to cervical spine and lumbar spine, and wheelchair due to noncompliance with MTUS and Official Disability Guidelines. Percocet 10/325 mg QTY: 36 was modified according to MTUS guidelines.

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

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

#### **Cervical Spine MRI QTY: 1.00: 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), 2014, On-Line, Indications for Imaging

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

**Decision rationale:** The records do not document red flag findings or specific neurological deficits or a specific neurological differential diagnosis to support an indication for a cervical MRI.

#### **Lumbar Spine MRI QTY: 1.00: 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), 2014, On-Line, Indications for Imaging

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

**Decision rationale:** The records do not document red flag findings or specific neurological deficits or a specific neurological differential diagnosis to support an indication for a lumbar MRI.

#### **Physical Therapy to Cervical Spine and Lumbar Spine QTY: 12.00: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active.

**Decision rationale:** This patient would have been anticipated to have transitioned by now to an independent home rehabilitation program. The records do not document a rationale at this time for supervised rather than independent home rehabilitation.

#### **Wheelchair QTY: 1.00: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Chapter

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Recommend manual wheelchair if the patient requires and will use a wheelchair to move around in their residence, and it is prescribed by a physician

**Decision rationale:** A treating physician note of 1121/14 reports that the patient had an increase in pain and is unable to stand or walk for long periods of time. Recommend manual wheelchair if the patient requires and will use a wheelchair to move around in their residence, and it is prescribed by a physician. ODG supports the use of a manual wheelchair in this situation.

**Percocet 10/325mg QTY: 60.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, and Weaning Page(s): 80-83, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic back pain: Appears to be efficacious but limited for short-term pain relief, and long- t.

**Decision rationale:** The records do not document specific functional goals or functional benefit from opioid treatment. Additionally the patient does not have a diagnosis for which the treatment guidelines recommend ongoing opioid use. Overall, the 4 As of opioid management have not been met.