

<b>Case Number:</b>	CM15-0114226		
<b>Date Assigned:</b>	06/22/2015	<b>Date of Injury:</b>	04/24/2013
<b>Decision Date:</b>	07/23/2015	<b>UR Denial Date:</b>	05/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2015

### 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 60-year-old male, with a reported date of injury of 04/24/2013. The diagnoses include cervical stenosis, status post cervical decompression with fusion, and bilateral carpal tunnel syndrome. Treatments to date have included CT (computerized tomography) of the cervical spine, which showed C4-6 fusion; an MRI of the cervical spine, electrodiagnostic studies which showed moderately severe right carpal tunnel syndrome and moderate left carpal tunnel syndrome; and chiropractic treatment. The complex neurological consultation dated 04/27/2015 indicates that the injured worker continued to be bothered by both hands. She had numbness and tingling in both hands. The injured worker also had intermittent neck pain with spasms, numbness around her chin, and inside of the gums around the lower teeth. The physical examination showed diminished sensation in the right V3 branch of the trigeminal nerve around the chin as well as inside the gums inferiorly; tenderness throughout the upper neck in the midline; some trigger points over the trapezius; moderately reduced range of motion of the cervical spine; positive Tinel's and Phalen's signs at the carpal tunnel; full motor strength in the upper and lower extremities; diminished sensation to pinprick and soft touch in both hands in the median digits. The treating physician requested an MRI of the cervical spine and oral surgery consultation to evaluate the chin numbness.

### 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 ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178. Decision based on Non-MTUS Citation Official disability guidelines, Neck and Upper Back (Acute & Chronic) Chapter and under Magnetic resonance imaging (MRI).

**Decision rationale:** Based on the 04/27/15 progress report provided by treating physician, the patient presents with neck pain, numbness and tingling to both hands, and chin numbness. The patient is status post cervical decompression and fusion at C4-5 and C5-6 on 05/11/13. The request is for magnetic resonance imaging (MRI) of the cervical spine. RFA with the request not provided. Patient's diagnosis on 04/27/15 included industrial motor vehicle accident leading to an acute cervical spine injury with underlying disc disease status post cervical fusion, rule out pseudoarthrosis or disc protrusions above or below the fusion; symptomatic bilateral carpal tunnel syndrome; acute shingles on left hemiface; and numbness on right chin and upper extremities. Physical examination on 06/30/15 revealed decreased cervical spine range of motion, especially on extension 20 degrees, with pain at endpoints of motion. Examination of the wrists revealed positive Tinel's and decreased sensation in the median nerve bilaterally. Treatment to date included surgery, imaging and electrodiagnostic studies and chiropractic treatment. The patient is working regular duty, per 06/03/15 report. Treatment reports were provided from 04/27/13 - 06/30/15. 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, 'Neck and Upper Back (Acute & Chronic) Chapter and under 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 appeal letter dated 06/03/15, treater requests MRI of the cervical spine to "assess [the patient's] symptomatology in her hands, increased neck pain, and left-sided facial numbness. These symptoms would not normally be expected following a cervical fusion. It is reasonable to identify the source of the complaints. There is evidence that the symptoms are related to the nerve distribution of the head and cervical spine, and the increased symptomatology is cause for concern." The patient is post-op and guidelines would support repeat MRIs to evaluate the impact of surgical interventions, which might contribute to a significant change in symptoms. However, 06/17/14 report states the patient had cervical MRI on 05/07/13, cervical decompression and fusion surgery on 05/11/13, and postoperative MRI

already done on 05/12/13. In this case, there is no documentation or discussion of significant change in symptoms or findings. There is no discussion of progression of neurologic deficit, no red flags and no new injury to warrant a repeat MRI study. This request is not in accordance with guideline criteria. Therefore, the request IS NOT medically necessary.

**Oral surgery consultation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Chapter 7: Independent Medical Examinations and Consultations, page 127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), Independent medical examination and consultations. Ch: 7 page 127.

**Decision rationale:** Based on the 04/27/15 progress report provided by treating physician, the patient presents with neck pain, numbness and tingling to both hands, and chin numbness. The patient is status post cervical decompression and fusion at C4-5 and C5-6 05/11/13. The request is for oral surgery consultation. RFA with the request not provided. Patient's diagnosis on 04/27/15 included industrial motor vehicle accident leading to an acute cervical spine injury with underlying disc disease status post cervical fusion, rule out pseudoarthrosis or disc protrusions above or below the fusion; symptomatic bilateral carpal tunnel syndrome; acute shingles on left hemiface; and numbness on right chin and upper extremities. Physical examination on 06/30/15 revealed decreased cervical spine range of motion, especially on extension 20 degrees, with pain at endpoints of motion. Examination of the wrists revealed positive Tinel's and decreased sensation in the median nerve bilaterally. Treatment to date included surgery, imaging studies, chiropractic treatment. The patient is working regular duty, per 06/03/15 report. Treatment reports were provided from 04/27/13 - 06/30/15. ACOEM Practice Guidelines, 2nd Edition (2004), page 127 has the following: The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. Per 04/27/15 report, treater states "oral surgery consultation on an industrial basis to evaluate the chin numbness." UR letter dated 05/14/15 states that the requesting physician advised UR examiner, per conversation on 05/14/15 that "if a MRI of the Brain is approved, an Oral Surgery Consult is not medically necessary." UR examiner stated, "MRI of the Brain is approved. Therefore, the request for an Oral Surgery Consult is denied." The treater does not now explain why oral surgery consultation is needed. There are no potential surgical issues with dentition/jaw. The patient presents with some numbness on the opposite side of shingles, and consultation with neurology may be appropriate but it is not known what an oral surgeon would be able to do to help. The treater does not explain. The request IS NOT medically necessary.