

Case Number:	CM15-0173845		
Date Assigned:	09/15/2015	Date of Injury:	01/14/2008
Decision Date:	10/23/2015	UR Denial Date:	08/13/2015
Priority:	Standard	Application Received:	09/03/2015

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 January 14, 2008. Medical records indicate that the injured worker is undergoing treatment for displaced cervical intervertebral discs, cervical spine spinal stenosis, cervical radiculopathy, carpal tunnel syndrome, lateral epicondylitis, brachial neuritis unspecified and acquired spondylolisthesis. The injured worker is working full time with modifications. Current documentation dated July 23, 2015 notes that the injured worker rated her pain 4 out of 10 on the visual analogue scale. The injured workers activity level was unchanged and her quality of sleep was good. Examination of the bilateral elbows revealed tenderness to palpation over the lateral epicondyles. Range of motion was within normal limits. Right wrist examination revealed no tenderness and a normal range of motion. A Phalen's maneuver and Tinel's sign were positive. Examination of the right hand revealed tenderness to palpation over the metacarpophalangeal joint of the little finger. Examination of the left hand revealed slight atrophy of the thenar eminence. No tenderness was noted. Sensory examination was normal all over the body. Treatment and evaluation to date has included medications, x-rays of the cervical spine (7-28-2014), right elbow and hand injections, MRI of both elbows and a cervical fusion. Current medications include Trazadone, Voltaren 1% gel, Lidoderm 5% patch, Acyclovir, Albuterol Sulfate, Carafate, Estradiol, Famotidine, Levothyroid, Retin-a 0.05% cream, Temazepam, Venlafaxine Hcl, Celebrex, Neurontin, Amoxicillin and Flonase. Current requested treatments include a request for x-rays of the cervical spine, four views anteriorposterior-lateral, flexion

and extension. The Utilization Review documentation dated August 13, 2015 non-certified the request for x-rays of the cervical spine four views anteriorposterior-lateral, flexion and extension.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-rays cervical spine 4 views AP/Lat, flex, extension: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines -Neck and Upper Back.

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

Decision rationale: The 53 year old patient presents with cervical pain, cervical disc disorder, cervical radiculopathy, carpal tunnel syndrome, and lateral epicondylitis, as per progress report dated 07/23/15. The request is for X-Rays Cervical Spine 4 Views Ap/Lat, Flex, Extension. There is no RFA for this case, and the patient's date of injury is 01/14/08. The patient is status post C5-6 and C6-7 discectomy and neural foraminotomies, as per operative report dated 10/01/13. Medications, as per progress report dated 07/23/15, included Trazodone, Lidoderm patch, Voltaren gel, Acyclovir, Albutarol, Carafate, Estradiol, Famotidine, Levothyroid, Retin, Temazepam, Venlafaxine, Celebrex, Neurontin, Amoxicillin, and Flonase. Diagnoses, as per progress report dated 04/27/15, included acquired spondylolisthesis, brachial neuritis, cervical spinal stenosis, and cervical disc displacement. The patient is working full time, as per progress report dated 07/23/15. For special diagnostics, ACOEM Guidelines, Neck and Upper back chapter and Special Studies section, 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." Regarding cervical x-rays, ODG states "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, the request for x-rays of the cervical spine "to rule out instability of the spine" is noted in progress report dated 08/20/15 (after the UR denial date). Prior X-rays of the cervical spine, dated 07/08/14, revealed straightening of the cervical lordosis, status post C5-6 and C6-7 anterior decompression and fusion, and good alignment with stability on flexion and extension. The patient does suffer from neck pain, rated at 4/10, as per progress report dated 07/23/15. Physical examination, however,

did not reveal any neurologic deficits. ACOEM only supports the use of x-rays only with "unequivocal objective findings that identify specific nerve compromise on the neurological examination." Additionally, there is no new injury, red flags or recent surgical interventions that warrant a new set of x-rays. Hence, the request is not medically necessary.