

<b>Case Number:</b>	CM15-0003181		
<b>Date Assigned:</b>	01/14/2015	<b>Date of Injury:</b>	06/11/2012
<b>Decision Date:</b>	03/17/2015	<b>UR Denial Date:</b>	12/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2015

### 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:

This 54 year old female was injured in an industrial accident on 6/11/12 resulting from a fall and injuring her left shoulder, arm, low back and left leg. Her current complaints include constant neck pain with radiation to the bilateral upper extremities with pain intensity rating of 8/10; constant bilateral shoulder pain (9/10); limited shoulder range of motion; constant right wrist and hand pain (8/10), with weakness of bilateral upper extremities, constant low back pain with radiation to bilateral lower extremities 9/10) and constant bilateral knee pain with associated weakness (8/10). Her back pain is most problematic. Medications include topical creams. Treatment included physical therapy. Diagnostic studies include cervical MRI, electromyography/ nerve conduction velocity of the bilateral upper extremities, radiographs of right and left hands and elbows, pelvis, cervical area. Diagnoses were cervicogenic syndrome with protrusion at C4-5, radiculitis and radiculopathy; L2-3 and L4-5 protrusion/ extrusion, stenosis and spondylolisthesis; bilateral type II acromion with subacromial tendinitis and impingement syndrome. On 12/3/14 the treating physician requested MRI of the lumbar spine due to this area of pain most problematic. On 12/12/14 Utilization Review non-certified the request for MRI of the lumbar spine based on no documentation of clinical change, progression or focal findings on exam to support repeat imaging. MTUS was cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **MRI Lumbar Spine: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation LOW BACK CHAPTER, MRI

**Decision rationale:** The patient presents with constant neck pain with radiation to the bilateral upper extremities, constant bilateral shoulder pain, constant right wrist/hand pain with weakness of the bilateral upper extremities, and constant low back pain with radiation to the bilateral lower extremities. The request is for an MRI OF THE LUMBAR SPINE. The RFA is dated 12/03/2014 and the patient is currently temporarily totally disabled. The 07/21/2014 Qualified Medical Evaluation indicates that the patient did have a prior MRI of the lumbar spine on 10/16/2012. For special diagnostics, ACOEM Guidelines page 303 states, "An equivocal objective findings that identify specific nerve compromise on neurological examination are sufficient evidence to warrant imaging in patients who do not respond well to treatment and who could consider surgery an option. Neurological examination is less clear; however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study." ODG Guidelines on low back chapter MRI topic states that "MRI are tests of choice for patients with prior back surgery, but for uncomplicated low back pain with radiculopathy, not recommended until after at least 1 month of conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology" such as a tumor, infection, fracture, nerve compromise, recurrent disk herniation. The 07/21/2014 Qualified Medical Evaluation indicates that the patient had a prior MRI of the lumbar spine in 2012. The treater is requesting for an updated MRI of the lumbar spine. The reason for the request is not provided. In this case, there are no new injuries, no significant change in examination findings, no bowel/bladder symptoms, or new location of symptoms that would require additional investigation. The requested repeat MRI of the lumbar spine IS NOT medically necessary.