

<b>Case Number:</b>	CM15-0166608		
<b>Date Assigned:</b>	09/04/2015	<b>Date of Injury:</b>	03/16/2001
<b>Decision Date:</b>	10/09/2015	<b>UR Denial Date:</b>	08/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/25/2015

### 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: Texas, California

Certification(s)/Specialty: Family Practice

### 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 is a 55 year old female with a March 16, 2001 date of injury. A progress note dated July 14, 2015 documents subjective complaints muscle aches; hypersensitivity to the muscles; feels cognitively intact; hot and cold feelings in the bilateral arms; stabbing pain in the bilateral elbows; fingers curling bilaterally; pain in the bilateral wrists; leg pain; severe lower back pain which radiates into the buttocks; whole body shakes uncontrollably, worse on the right), Current diagnoses (reflex sympathetic dystrophy; complex regional dystrophy; hypercholesterolemia; osteoporosis). Objective findings were not documented for this date of service. Treatments to date have included spinal cord stimulators, medications, use of a wheelchair, and imaging studies. The medical record indicates that the provider desires to remove the spinal cord stimulators. The treating physician documented a plan of care that included magnetic resonance imaging of the brain, cervical spine, thoracic spine, and lumbar spine. The patient has had three to four SCS in thoracic spine and lumbar spine. The medication list include Lipitor, Dexilant, Cymbalta, Wellbutrin, and Lidoderm patch. The patient had received an unspecified number of PT visits for this injury. Physical examination on dated 5/22/15 revealed patient was wheelchair bound, patient was severe hypersensitive, unable to get out of wheelchair due to extensive pain, hyper reactive DTRs, and negative Babinski sign. A detailed recent physical examination of the cervical, lumbar and thoracic region was not specified in the records specified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of the brain, cervical, thoracic and lumbar with gadolinium: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, and Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies, and Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Head (updated 07/24/15); MRI (magnetic resonance imaging).

**Decision rationale:** Per the ACOEM low back guidelines cited below "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. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures)." Per the ACOEM chapter 8 guidelines cited below "For most patients presenting with true neck or upper back problems, special studies are not needed unless a three or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out." Per the ACOEM chapter 8 guidelines cited below recommend "MRI or CT to evaluate red-flag diagnoses as above, MRI or CT to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. If no improvement after 1 month bone scans if tumor or infection possible, not recommended: Imaging before 4 to 6 weeks in absence of red flags." Per the guidelines cited below, brain MRI is recommended for "to determine neurological deficits not explained by CT, to evaluate prolonged interval of disturbed consciousness, and to define evidence of acute changes super-imposed on previous trauma or disease." Evidence of prolonged interval of disturbed consciousness, or evidence of acute changes super-imposed on previous trauma or disease was not specified in the records provided. Patient did not have consistent objective evidence of severe or progressive neurologic deficits that are specified in the records provided. The records provided did not specify objective evidence of abnormal neurological findings or red flags. The records provided do not specify significant objective evidence of consistently abnormal neurological findings including abnormal EDS (electro-diagnostic studies). Findings indicating red flag pathologies were not specified in the records provided. The history or physical exam findings did not indicate pathology including cancer, infection, or other red flags. As per records provided patient has received an unspecified number of PT visits for this injury till date. A detailed response to a complete course of conservative therapy including PT visits was not specified in the records provided. Previous PT visit notes were not specified in the records provided. A plan for an invasive procedure was not specified in the records provided. The medical necessity of the request for gadolinium contrast was not specified in the records provided. The medical necessity of the MRI of the brain, cervical, thoracic and lumbar with gadolinium is not medically necessary for this patient.