

<b>Case Number:</b>	CM15-0202026		
<b>Date Assigned:</b>	10/16/2015	<b>Date of Injury:</b>	08/05/2015
<b>Decision Date:</b>	12/02/2015	<b>UR Denial Date:</b>	10/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/14/2015

### 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, District of Columbia,  
 Maryland Certification(s)/Specialty: Anesthesiology, Pain  
 Management

### 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 73 year old female, who sustained an industrial injury on 8-5-2015. The medical records indicate that the injured worker is undergoing treatment for possible cervical sprain-strain, possible right cervical facet pain C4-C5, C5-C6, possible cervical discogenic pain, possible lumbar sprain-strain, possible bilateral lumbar facet pain L4-L5, L5-S1, and possible lumbar discogenic pain. According to the progress report dated 9-28-2015, the injured worker presented with complaints of constant neck pain with radiation into the right shoulder and right upper extremity. In addition, she reports intermittent low back pain. The level of pain is not rated. The physical examination of the cervical spine reveals midline tenderness, right facet tenderness C4-C5, C5-C6, right trapezius tenderness, positive facet loading, and painful range of motion. Examination of the lumbar spine reveals bilateral facet tenderness L4-L5, L5-S1, positive facet loading, and painful range of motion. The medications prescribed are Anaprox, Prilosec, and Flexeril. Previous diagnostic studies include x-rays of the cervical and lumbar spine. Treatments to date include medication management and chiro-physiotherapy. Work status is described as temporary total disability. The original utilization review (10-8-2015) had non-certified a request for MRI of the lumbar and cervical spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **MRI of the Lumbar Spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, MRIs (Magnetic resonance imaging).

**Decision rationale:** Per the ODG guidelines with regard to MRI of the lumbar spine: Recommended for indications below. MRI's are test of choice for patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy, not recommended until after at least one month 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 (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). (Bigos, 1999) (Mullin, 2000) (ACR, 2000) (AAN, 1994) (Aetna, 2004) (Airaksinen, 2006) (Chou, 2007) Magnetic resonance imaging has also become the mainstay in the evaluation of myelopathy. An important limitation of magnetic resonance imaging in the diagnosis of myelopathy is its high sensitivity. Indications for imaging Magnetic resonance imaging: Thoracic spine trauma: with neurological deficit Lumbar spine trauma: trauma, neurological deficit Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit) Uncomplicated low back pain, suspicion of cancer, infection, other red flags. Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. Uncomplicated low back pain, prior lumbar surgery, Uncomplicated low back pain, cauda equina syndrome Myelopathy (neurological deficit related to the spinal cord), traumatic Myelopathy, painful Myelopathy, sudden onset Myelopathy, stepwise progressive Myelopathy, slowly progressive Myelopathy, infectious disease patient Myelopathy, oncology patient Repeat MRI: When there is significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation)The documentation submitted for review does not contain positive physical examination findings regarding the lumbar spine or indication of subjective complaints of pain to the lumbar spine noted for review that would support the role of an MRI. There are no documented motor, sensory or functional deficits, or aforementioned indication. Without evidence of acute change in injured worker's clinical symptoms or positive physical examination findings, an MRI is not supported. The request is not medically necessary.

## **MRI of the Cervical Spine: Overturned**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Magnetic resonance imaging (MRI).

**Decision rationale:** Per the ODG guidelines with regard to MRI of the lumbar spine: "Not recommended except for indications list 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. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). (Anderson, 2000) (ACR, 2002) See also ACR Appropriateness Criteria". MRI imaging studies are valuable when physiologic evidence indicates tissue insult or nerve impairment or potentially serious conditions are suspected like tumor, infection, and fracture, or for clarification of anatomy prior to surgery. MRI is the test of choice for patients who have had prior back surgery. (Bigos, 1999) (Bey, 1998) (Volle, 2001) (Singh, 2001) (Colorado, 2001) For the evaluation of the patient with chronic neck pain, plain radiographs (3-view: anteroposterior, lateral, open mouth) should be the initial study performed. Patients with normal radiographs and neurologic signs or symptoms should undergo magnetic resonance imaging. If there is a contraindication to the magnetic resonance examination such as a cardiac pacemaker or severe claustrophobia, computed tomography myelography, preferably using spiral technology and multiplanar reconstruction is recommended. (Daffner, 2000) (Bono, 2007) Indications for imaging MRI (magnetic resonance imaging) Chronic neck pain (= after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present Neck pain with radiculopathy if severe or progressive neurologic deficit Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present Chronic neck pain, radiographs show bone or disc margin destruction Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal" Known cervical spine trauma: equivocal or positive plain films with neurological deficit- Upper back/thoracic spine trauma with neurological deficit The injured worker presented with complaints of constant neck pain with radiation into the right shoulder and right upper extremity. The request is medically necessary.