

<b>Case Number:</b>	CM15-0033244		
<b>Date Assigned:</b>	02/26/2015	<b>Date of Injury:</b>	07/27/2013
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	01/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/23/2015

### 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, Indiana, New York  
Certification(s)/Specialty: Internal Medicine

### 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 49 year old female sustained an industrial injury on 7/27/13 with subsequent ongoing neck and back pain. Electromyography/nerve conduction velocity test (6/3/14) showed right L5 radiculopathy. Magnetic resonance imaging lumbar spine (7/15/14) showed disc protrusions with bilateral neural foraminal stenosis. Magnetic resonance imaging cervical spine (7/15/14) showed disc protrusions with facet arthropathy and neural foraminal stenosis. Treatment included epidural steroid injections and medications. On 9/22/14, an orthopedic surgeon reviewed the magnetic resonance imaging results and determined that the injured worker was not a surgical candidate at this time. The physician recommended x-rays of the lumbar spine, five views plus flexion/extension views, epidural steroid injections and follow up in three months to reevaluate. In a PR-2 dated 11/12/14, the injured worker reported that epidural steroid injection on 10/30/14 had provided up to 70% relief of low back pain and lower extremity radicular symptoms. The injured worker rated her low back pain from 3/10 on the visual analog scale. The injured worker complained of ongoing neck pain. The treatment plan included trigger point injections to the neck and continuing medications Norco, Anaprox and Prilosec. On 1/23/15, Utilization Review noncertified a request for magnetic resonance imaging cervical spine and magnetic resonance imaging lumbar spine noting magnetic resonance imaging scans completed on 7/15/14 with unclear documentation as to why repeat scans would be needed so soon and citing ACOEM guidelines. As a result of the UR denial, an IMR was filed with the Division of Workers Comp.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of the cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section, MRI.

**Decision rationale:** Pursuant to the Official Disability Guidelines, MRI cervical spine is not medically necessary. 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 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 a computer tomography (CT). The indications for imaging are enumerated in the Official Disability Guidelines. Indications include, but are not limited to, chronic neck pain (after three months conservative treatment), radiographs normal neurologic signs or symptoms present; neck pain with radiculopathy if severe or progressive neurologic deficit; etc. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). The criteria for ordering an MRI of the cervical spine include the emergence of a red flag, physiologic evidence of tissue insult when nerve impairment, failure to progress in a strengthening program intended to avoid surgery and clarification of anatomy prior to surgery. The ACOEM states (chapter 8 page 178) unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging if symptoms persist. In this case, the injured worker's working diagnoses are lumbar myoligamentous injury with right lower extremity radicular symptoms; cervical myoligamentous injury; and right elbow contusion, resolved. An MRI of the cervical spine was performed on July 14, 2014. At C4 - C5, there is a 2.1 mm disc protrusion with associated facet arthropathy and bilateral neural foraminal stenosis which deforms the bilateral C5 exiting nerve root. At C5 - C6, there is a 1.7 mm this protrusion with associated facet arthropathy that deviates the bilateral C6 exiting nerve roots. Subjectively, the injured worker recently underwent a second epidural steroid injection that provided excellent relief. Objectively, there was tenderness palpation bilaterally with increased muscle rigidity in the cervical and lumbar spine. Range of motion is decreased. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). There are no new significant clinical symptoms or signs suggestive of significant pathology. Consequently, absent compelling clinical documentation with significant new symptoms or clinical objective findings suggestive of significant pathology, MRI cervical spine is not medically necessary.

**MRI of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-5. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, MRI.

**Decision rationale:** Pursuant to the Official Disability Guidelines, MRI of the lumbar spine is not medically necessary. MRIs of the test of choice in patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy, it is 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 findings suggestive of significant pathology. Indications (enumerated in the Official Disability Guidelines) for imaging include, but are not limited to, lumbar spine trauma, neurologic deficit; uncomplicated low back pain with red flag; uncomplicated low back pain prior lumbar surgery; etc. ACOEM states unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients not respond to treatment and who would consider surgery an option. See the ODG for details. In this case, the injured worker's working diagnoses are lumbar myoligamentous injury with right lower extremity radicular symptoms; cervical myoligamentous injury; and right elbow contusion, resolved. Lumbar spine MRI was performed July 15, 2014. The findings included a 2.2 mm disc protrusion at L3 - L4, L4 - L5, and L5 - S1 with bilateral neural foraminal stenosis. Subjectively, the injured worker recently underwent a second epidural steroid injection that provided excellent relief. Objectively, there was tenderness palpation bilaterally with increased muscle rigidity in the cervical and lumbar spine. Range of motion is decreased. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). There are no new significant clinical symptoms or signs suggestive of significant pathology. Consequently, absent compelling clinical documentation with significant new symptoms or clinical objective findings suggestive of significant pathology, MRI lumbar spine is not medically necessary.