

<b>Case Number:</b>	CM15-0042962		
<b>Date Assigned:</b>	03/13/2015	<b>Date of Injury:</b>	05/02/2011
<b>Decision Date:</b>	04/17/2015	<b>UR Denial Date:</b>	02/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/09/2015

### 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: Montana

Certification(s)/Specialty: Preventive Medicine, Occupational 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:

The injured worker is a 53 year old male, who sustained an industrial injury on May 2, 2011. He has reported neck pain radiating to the scapula and arm with numbness and tingling of the hand, numbness of the left forearm, headache, and lower back pain radiating to the bilateral legs. Diagnoses have included neck pain, cervicogenic headache, left ulnar neuropathy, cervical spine degenerative disc disease and degenerative joint disease, cervical spine radiculopathy, and major depression. Treatment to date has included medications, cervical spine facet blocks, physical therapy, acupuncture, and imaging studies. A progress note dated January 22, 2015 indicates a chief complaint of neck pain radiating to the scapula and arm with numbness and tingling of the hand, numbness of the left forearm with decreased fine motor control, occasional headache, and lower back pain radiating to the bilateral legs. The treating physician documented a plan of care that included injections, physical therapy, medications, electromyogram, and magnetic resonance imaging of the lumbar spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar MRI without contrast:** 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): 303-304 and 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back, MRI.

**Decision rationale:** The MTUS states that 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 and option. Indiscriminate imaging will result in false positive finding such as disc bulges that are not the source of painful symptoms and do not warrant surgery. Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion because of the overall false positive rate of 30%. The ODT guidelines document that 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. Magnetic resonance imaging has also become the mainstay in the evaluation of myelopathy. Indications (ODG) for Magnetic resonance imaging (MRI):- 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 In this case, while there is increased low back pain, there is no documentation of myelopathy, progressive neurologic deficit or radiculopathy with neurologic deficit related to specific nerve compromise that would meet the criteria for a repeat lumbar MRI. Deep tendon reflexes and straight leg raising tests are negative bilaterally. No red flag conditions are identified. The request for MRI of the lumbar spine is not medically necessary.