

<b>Case Number:</b>	CM15-0050130		
<b>Date Assigned:</b>	03/23/2015	<b>Date of Injury:</b>	03/24/2007
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/17/2015

### 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:

The injured worker is a 38 year old male, who sustained an industrial injury on 3/24/2007. He reported pain in his lower back. Diagnoses have included cervicalgia, thoracalgia and lumbar disc injury. Treatment to date has included lumbar surgery, acupuncture, physical therapy, trigger point injections and medication. According to the orthopedic evaluation dated 12/24/2014, the injured worker complained of low, mid and upper back pain. He rated his low back pain as 8/10 on the visual analog scale (VAS). The pain in the low back radiated down both legs, right greater than left. He also described inflammation in the sole of his left foot. He had difficulty bending and twisting. He rated his mid to upper back pain as 9/10. He also complained of pain in both shoulder blades. He reported that his legs and hands often went numb, particularly with prolonged driving. Physical exam revealed guarding in the right buttock, right calf and right foot. The treatment plan was for lumbar, cervical and thoracic magnetic resonance imaging (MRI).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of the thoracic spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Lumbar & Thoracic (Acute & Chronic), MRIs (magnetic resonance imaging).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

**Decision rationale:** This patient presents with low back, mid-back, and upper back pain. The patient also complains of low back pain radiating down the bilateral legs, right greater than the left. The physician is requesting an MRI of the thoracic spine. The RFA was not made available for review. The patient's date of injury is from 03/24/2007, and he is currently not working. The ACOEM Guidelines Chapter 8 page 177 to 178 on Neck and Upper Back Complaints list the criteria for ordering imaging studies, which include emergency of a red flag; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery and clarification of anatomy prior surgery or procedure. ACOEM further states that unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence toward imaging studies if symptoms persist. The records do not show any previous MRI of the thoracic spine. The 12/24/2014 report showed normal shoulder range of motion. Control points are positive bilaterally in the upper extremities. There is deficit at the C8 ulnar nerve in the left upper extremity. There is guarding in the right buttock, right calf, and right foot. Deep tendon reflexes are within normal limits bilaterally. Right sitting straight leg raise is 40 degrees with pain in the buttocks, calf, and foot. Left sitting straight leg raise on the left crosses over causing pain on the right side. There are no discussions of neurological or sensory deficits in the thoracic spine. In this case, the patient does not meet the criteria for an MRI of the thoracic spine. The request is not medically necessary.

**MRI of the cervical spine:** Overturned

**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): 177-178. Decision based on Non-MTUS Citation Official disability guidelines Neck & upper back chapter, MRIs.

**Decision rationale:** This patient presents with low back, mid-back, and upper back pain. The patient also complains of low back pain radiating down the bilateral legs. The physician is requesting an MRI of the cervical spine. The RFA was not made available for review. The patient's date on injury is from 03/24/2007, and he is currently not working. The ACOEM Guidelines Chapter 8 page 177 and 178 on neck and upper back complaints: (1) emergence of a red flag, (2) physiologic evidence of tissue insult or neurologic dysfunction, (3) failure to progress in the strengthening program intended to avoid surgery, (4) clarification of anatomy prior to invasive procedure. In addition, ODG Guidelines under the Neck chapter on MRIs state, "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). 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." The records do not show any previous MRI of the cervical spine. The examination from the 12/24/2014 report showed deficit at C8 ulnar nerve in the left upper extremity. Straight leg raise is positive bilaterally. Testing of the cubital tunnel on the right and left is 2. Testing of the canal of Guyon on the right and left is 2. Carpal tunnel testing bilaterally is 2. Control points are also positive bilaterally. In this case, the physician has noted a neurological deficit and an MRI of the cervical spine is appropriate. The request is medically necessary.

**MRI of the lumbar spine:** Overturned

**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. Decision based on Non-MTUS Citation Official disability guidelines Low Back chapter on MRI.

**Decision rationale:** This patient presents with low back, mid-back, and upper back pain. The patient also complains of low back pain radiating down the bilateral legs. The physician is requesting an MRI of the lumbar spine. The RFA was not made available for review. The patient's date of injury is from 03/24/2007, and he is currently not working. The ACOEM Guidelines Chapter 12 on Low Back Complaints page 303 on MRI for back pain 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 would consider surgery as an option. When the neurologic examination is less clear, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. ODG Guidelines under the Low Back chapter on MRI also states that repeat MRIs are not routinely recommended and should be reserve for significant change in symptoms and/or findings suggestive of significant pathology e.g. tumor, infection, fracture, nerve compression, and recurrent disk herniation. The records do not show any previous MRI of the lumbar spine. The 12/24/2014 progress report showed a positive straight leg raise bilaterally. Motor examination of the lower extremities was nonspecific with no focal deficits bilaterally. Sensory examination of the lower extremities was nonspecific with no focal deficits bilaterally. In this case, the reports show radiating pain down the bilateral legs and a positive straight leg raise bilaterally. Given the patient's symptoms and examination findings, an MRI is appropriate. The request is medically necessary.