

<b>Case Number:</b>	CM14-0162357		
<b>Date Assigned:</b>	10/07/2014	<b>Date of Injury:</b>	03/14/2013
<b>Decision Date:</b>	10/31/2014	<b>UR Denial Date:</b>	09/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/02/2014

### 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. The expert reviewer is Board Certified in Occupational Medicine, has a subspecialty in Internal Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, this is a 57-year-old female with a 3/14/13 date of injury. At the time (8/28/14) of request for authorization for Bilateral Lumbar Injections at L2-L3, L4-L5 and L5-S1, MRI of the Cervical Spine, and MRI of the Lumbar Spine, there is documentation of subjective (low back pain radiating to hips, chronic numbness over bilateral feet/ankles, neck pain, and left trochanteric pain) and objective (restricted cervical spine range of motion and decreased sensory exam from right ankles down to feet as well as left leg/foot) findings, imaging findings (MRI lumbar spine (11/22/13) report revealed diffuse degenerative disc disease with mild to moderate annular disc bulge at L2-3 with no focal disc herniation and no neural foraminal compromise; mild diffuse annular disc bulge at L4-5 with no disc herniation or central canal or neural foraminal compromise; and minimal annular disc bulge at L5-S1 with no disk herniation or central canal or neural foraminal compromise; and MRI cervical spine (11/22/13) report revealed minimal annular disc bulge on left C5-6 with mild foraminal compromise and moderate right C3-4 foraminal compromise), current diagnoses (herniated cervical intervertebral disc, peripheral neuropathy, C5-6 and C6-7 spinal stenosis, mechanical axial back pain lumbar spine, and left trochanteric bursitis), and treatment to date (chiropractic treatment, physical therapy, activity modifications, and medications). Medical report identifies a request for repeat lumbar and cervical MRI scan prior to qualified medical evaluation. Regarding lumbar injections, there is no documentation of imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression or moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels. Regarding MRI cervical spine and lumbar spine, there is no documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeated study is indicated (to diagnose a suspected fracture or suspected dislocation, to monitor a therapy or

treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings).

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Bilateral Lumbar Injections at L2-L3, L4-L5 and L5-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Epidural Steroid Injections (ESIs)

**Decision rationale:** MTUS reference to ACOEM guidelines identifies documentations of objective radiculopathy in an effort to avoid surgery as criteria necessary to support the medical necessity of epidural steroid injections. ODG identifies documentation of subjective (pain, numbness, or tingling in a correlating nerve root distribution) and objective (sensory changes, motor changes, or reflex changes (if reflex relevant to the associated level) in a correlating nerve root distribution) radicular findings in each of the requested nerve root distributions, imaging (MRI, CT, myelography, or CT myelography & X-ray) findings (nerve root compression or moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels, failure of conservative treatment (activity modification, medications, and physical modalities), and no more than two nerve root levels injected one session; as criteria necessary to support the medical necessity of lumbar epidural steroid injection. Within the medical information available for review, there is documentation of diagnoses of herniated cervical intervertebral disc, peripheral neuropathy, C5-6 and C6-7 spinal stenosis, mechanical axial back pain lumbar spine, and left trochanteric bursitis. In addition, there is documentation of subjective (pain and numbness) and objective (sensory changes and motor changes) radicular findings in each of the requested nerve root distributions; imaging findings (MRI lumbar spine identifying diffuse degenerative disc disease with moderate annular disc bulge at L2-3); and failure of conservative treatment (activity modification, medications, and physical modalities). However, despite documentation of imaging findings (MRI lumbar spine identifying MILD diffuse annular disc bulge at L4-5 with no disc herniation or central canal or neural foraminal compromise; and MINIMAL annular disc bulge at L5-S1 with no disk herniation or central canal or neural foraminal compromise), there is no documentation of imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR MODERATE or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels. Therefore, based on guidelines and a review of the evidence, the request for Bilateral Lumbar Injections at L2-L3, L4-L5 and L5-S1 is not medically necessary.

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

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-183. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Minnesota Rules, Parameters for Medical Imaging

**Decision rationale:** MTUS reference to ACOEM Guidelines identifies documentation of red flag diagnoses where plain film radiographs are negative, physiologic evidence (in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans) of tissue insult or neurologic dysfunction, failure of conservative treatment; or diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure; as criteria necessary to support the medical necessity of an MRI. ODG identifies documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (such as: to diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings) as criteria necessary to support the medical necessity of a repeat MRI. Within the medical information available for review, there is documentation of diagnoses of herniated cervical intervertebral disc, peripheral neuropathy, C5-6 and C6-7 spinal stenosis, mechanical axial back pain lumbar spine, and left trochanteric bursitis. In addition, there is documentation of a 2013 MRI of cervical spine identifying minimal annular disc bulge on left C5-6 with mild foraminal compromise and moderate right C3-4 foraminal compromise. However, despite documentation of rationale for a repeat cervical MRI prior to qualified medical evaluation, there is no documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeated study is indicated (to diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings). Therefore, based on guidelines and a review of the evidence, the request for MRI of the Cervical Spine is not medically necessary.

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

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Minnesota Rules, Parameters for Medical Imaging

**Decision rationale:** MTUS reference to ACOEM guidelines identifies documentation of red flag diagnoses where plain film radiographs are negative; objective findings that identify specific nerve compromise on the neurologic examination, failure of conservative treatment, and who are considered for surgery, as criteria necessary to support the medical necessity of MRI. OGD identifies documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (such as: to diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings) as criteria necessary to support the medical necessity of a repeat MRI. Within the medical information available for review, there is documentation of a diagnosis of herniated cervical intervertebral disc, peripheral neuropathy, C5-6 and C6-7 spinal stenosis, mechanical axial back pain lumbar spine, and left trochanteric bursitis. In addition, there is documentation of a 2013 MRI of lumbar spine identifying diffuse degenerative disc disease with mild to moderate annular disc bulge at L2-3, mild diffuse annular disc bulge at L4-5, and minimal annular disc bulge at L5-S1. However, despite documentation of rationale for a repeat lumbar MRI prior to qualified medical evaluation, there is no documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeated study is indicated (to diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings). Therefore, based on guidelines and a review of the evidence, the request for MRI of the Lumbar Spine is not medically necessary.