Case Number:	CM14-0212760		
Date Assigned:	12/30/2014	**Date of Injury:**	01/10/2006
Decision Date:	03/03/2015	**UR Denial Date:**	12/01/2014
Priority:	Standard	**Application Received:**	12/19/2014

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. 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: New Jersey, Michigan, California
Certification(s)/Specialty: Neurology, Neuromuscular 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 patient is a 65-year-old woman who sustained a work-related injury on January 10, 2006. Subsequently, she developed low back, neck, and shoulders pain. Prior treatments included: physical therapy, TENS, C5-6 cervical fusion, revision of right knee replacement, medications, and epidural steroid injection. EMG/NCS performed on October 26, 2012 documented a normal electromyography of both lower extremities and lumbosacral paraspinous muscle bilaterally. There was abnormal NCS due to markedly prolonged personeal F-wave on the left. In addition, there was a decrease in amplitude of the H-reflex on the left and absent sural nerves bilaterally. MRI of the lumbar spine dated July 23, 2013 showed a mild disc height loss at L3-4. There was a 1-2 mm disc bulge and there was mild spinal canal stenosis. At L4-5, there was mild moderate disc height loss. There was 2 mm disc bulge. The spinal canal was patent. There was mild to moderate bilateral neural for a stenosis. At L5-S1, there was mild to moderate right neural foraminal stenosis. The left neural foramen was mildly stenotic. X-ray of the right shoulder reviewed on November 19, 2014 showed type II acromion and mild acromioclavicular osteoarthritis. X-ray of the lumbar spine reviewed on November 19, 2014 showed lumbar spondylosis with degenerative disc disease, facet arthropathy, and grade I spondylolisthesis at L4-L5. According to the progress report November 17, 2014, the patient complained of cervical spine pain with referred pain into the right shoulder and right upper extremity. She reported decreased painful range of motion of her neck. She also complained of right shoulder pain, which was aggravated by activity. The patient complained of lumbar spine pain as well, with radicular pain into the legs. She reported pain with knee motion. Examination of the cervical

spine revealed an anterior cervical scar. There was diffuse tenderness to palpation of the paraspinal muscle groups of the lower cervical spine. There was mildly decreased cervical lordosis. She had decreased range of motion. There was pain at the extremes of cervical spine motion. The patient did not have any radicular pain into the arms with axial loading, full extension or full flexion of the cervical spine. Spurling's test was negative bilaterally. Examination of the shoulders revealed decreased right shoulder motion. There was tenderness to palpation over the right biceps tendon. Active range of motion was limited for the right shoulder. Cross body adduction test produced mild pain on the right shoulder. The apprehension, sulcus and jerk tests were negative on the right shoulder. Examination of the lumbar spine revealed decreased lumbar lordosis. There was lumbar pain, which was aggravated by lumbar motion. There was pain noted with extremes of motion. The patient had decreased hip flexion secondary to back pain. The patient was diagnosed with cervical spondylosis with multi-level degenerative disc disease, right shoulder impingement syndrome, lumbar spondylosis with multi-level degenerative disc disease, and grade I spondylolisthesis. The provider requested authorization for MRI lumbar 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 ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back (updated 10/28/14) MRIs

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: Regarding the indications for imaging in case of back pain, MTUS guidelines stated: Lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. However, it may be appropriate when the physician believes it would aid in patient management. 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 an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). Furthermore, and according to MTUS guidelines, MRI is the test of choice for patients with prior back surgery, fracture or tumors that may require surgery. The patient does not have any clear evidence of new lumbar nerve root compromise. There is no clear evidence of significant change in the patient signs or symptoms suggestive of new pathology. Therefore, the request for lumbar MRI is not medically necessary.