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| <b>Case Number:</b>   | CM15-0126386 |                              |            |
| <b>Date Assigned:</b> | 07/29/2015   | <b>Date of Injury:</b>       | 01/17/2012 |
| <b>Decision Date:</b> | 09/01/2015   | <b>UR Denial Date:</b>       | 06/18/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 06/30/2015 |

### 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: New Jersey

Certification(s)/Specialty: Family Practice

### 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 51 year old female, who sustained an industrial injury on 1/17/12. Initial complaints were not reviewed. The injured worker was diagnosed as having lumbago; (status post lumbar L5-S1 fusion 2007); chronic pain syndrome; muscle spasms; lumbago; cervicalgia; thoracic or lumbosacral neuritis or radiculitis unspecified; brachial neuritis or radiculitis NOS; degeneration of the thoracic and lumbar intervertebral disc; headache. Treatment to date has included physical therapy; bilateral S1 epidural steroid injection (10/2014); medications. Diagnostics studies included MRI cervical spine (1/24/14); MRI brain (5/29/14); MRI lumbar spine (5/29/13). Currently, the PR-2 notes dated 6/16/15 indicated the injured worker has a history of posterior neck and low back pain with right leg pain in the setting of lumbar degenerative disc disease (DDD), cervical degenerative disc disease (DDD), lumbar and cervical facet osteoarthritis (OA). She has had a lumbar fusion at L5-S1 in 2007. She presents on this date for a routine office visit and states she has had an increase in her headaches and neck pain as well as her low back pain right greater than left. She states her pain levels have been 8-9/10 with medications and 10/10 without. She reports that the benefit of chronic pain medications maintenance regimen, activity restrictions and rest continue to keep pain within a manageable level and allow her to complete necessary activities of daily living. She indicates ice packs help her cervical pain. Her lower extremities are increasingly painful and getting weaker and she has now fallen several times while ambulating. This is very concerning for her. She is working 15 hours a week and with current treatment is able to return to work and works about 10-12 hours a week. The provider lists her medications as: Dexilant 60mg, Soma 350mg, Lidocaine patch;

Voltaren gel; ibuprofen 600mg, Propranolol 20mg, Cymbalta 30mg, Tizanidemp 2mg, Lidoderm 5, Furosemide 20mg, Bayer Aspirin 80mg and Carisoprodol 350mg. On physical examination the provider documents tenderness and tightness over the cervical spine along with the entire thoracic spine. Range of motion is decreased by 50% in all planes with negative Spurling's. The lumbar spine notes increased tenderness and tightness across the lumbosacral area right greater than left. She has a decreased range of motion for forward flexion 70% restricted and lateral bending is 50% restricted with dyesthesias and hypoesthesia to the bilateral legs and extension is 30% restricted. She has negative straight leg raise. The provider reports hypoesthesia and dysesthesia down the anterior and posterior right leg. She has had a MRI of the brain 5/29/14 which is reported as normal. A MRI lumbar spine of 5/29/13 revealed at L2-3 there is a right disc protrusion. At L3-4 and L4-5, there is a disc bulge and left lateral disc protrusion. At L5-S1, there is a posterior fusion and bilateral recess stenosis. There is impingement of the S1 nerve roots and there is facet osteoarthritis throughout. The MRI of the cervical spine dated 1/24/13 revealed disc bulges at C4-5, C5-6 and C6-7. A MRI of the thoracic spine dated 11/14/14 revealed disc degeneration of T6-7 through T9-10 and mild endplate spurring at multiple levels. Otherwise, this was an unremarkable study. The provider is requesting authorization of Lumbar MRI with contrast.

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

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

**Lumbar MRI with contrast:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 52.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 296-310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back section, MRI.

**Decision rationale:** MTUS Guidelines for diagnostic considerations related to lower back pain or injury require that for MRI to be warranted there needs to be unequivocal objective clinical findings that identify specific nerve compromise on the neurological examination (such as sciatica) in situations where red flag diagnoses (cauda equina, infection, fracture, tumor, dissecting/ruptured aneurysm, etc.) are being considered, and only in those patients who would consider surgery as an option. In some situations where the patient has had prior surgery on the back, MRI may also be considered. The MTUS also states that if the straight-leg-raising test on examination is positive (if done correctly) it can be helpful at identifying irritation of lumbar nerve roots, but is subjective and can be confusing when the patient is having generalized pain that is increased by raising the leg. The Official Disability Guidelines (ODG) state that for uncomplicated low back pain with radiculopathy MRI is not recommended until after at least one month of conservative therapy and sooner if severe or progressive neurologic deficit is present. The ODG also states that repeat MRI should not be routinely recommended, and should only be reserved for significant changes in symptoms and/or findings suggestive of significant pathology. The worker in this case according to the records provided, was experiencing progressively worsening lower back and leg symptoms suggestive of worsening lumbar radiculopathy based on history and physical examination compared to prior notes. However, no

evidence was found from examination or history to suggest there was cancer or infection to warrant an MRI with contrast as opposed to one without contrast which is more appropriate for reassessment in this particular worker. Therefore, although an MRI without contrast would be warranted here, the request for lumbar MRI with contrast is not medically necessary as ordered and requested.