

<b>Case Number:</b>	CM15-0176183		
<b>Date Assigned:</b>	09/17/2015	<b>Date of Injury:</b>	03/01/2013
<b>Decision Date:</b>	10/20/2015	<b>UR Denial Date:</b>	08/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/08/2015

### 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, Indiana, New York  
 Certification(s)/Specialty: Internal 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 47-year-old female, who sustained an industrial injury on 3-1-13. The injured worker has complaints of intractable low back pain radiating into both lower extremities, left worse than the right. The documentation noted on 6-24-15 the injured workers pain level is 7 to 9 on a scale of 0 to 10. The pain is sharp, shooting, stabbing and burning in nature. The injured worker states weakness, numbness, tingling sensation and paresthesia in the left leg. Cervical spine complained of pain 6 to 7 on a scale of 0 to 10 in the cervical spine radiating to bilateral shoulders and bilateral upper extremities. The injured worker is complaining of pain in her both knees, greater on the left than on the right, pain in the knees increases on prolonged standing and walking and reports propping and giving out of her knees off and on. Physical examination revealed lumbar spine is tender from L3 through L5 level bilaterally, there is bilateral lumbar facet tenderness at L3-L4, L4-L5 and L5-S1 (sacroiliac) level, and the pain in the lumbar spine worsens on extension, side bending and rotation of the spine. Range of motion of the lumbar spine is limited. Sciatic notch tenderness is negative bilaterally. Straight leg raising test is positive on the left and 45 degrees elevation of the leg and at 60 degrees elevation of the leg in the right side. There is weakness in the right lower extremity in L4-L5 myotomes. Cervical spine is tender form C3 through C6 level bilaterally and there is bilateral cervical facet tenderness at C5-C6, C6-C7 level. The documentation noted on 7-29-15 the injured worker has tenderness, spasms and pain with flexion and extension. Magnetic resonance imaging (MRI) of the cervical spine shows a large herniated disc at C6-c7; magnetic resonance imaging (MRI) of the lumbar spine on 5-24-13 showed lumbar disc

protrusion 5 to 7 millimeter at L4-L5 and L5-S1 (sacroiliac) level causing compression on the cal sac. Magnetic resonance imaging (MRI) of the right shoulder showed superior labrum, anterior to posterior tear in the right shoulder and partial tear in the left shoulder as well as rotator cuff tear in the left shoulder along with this tendonitis. The diagnoses have included left lumbar radiculopathy with neuroclaudication and large herniated disc, lumbar spine at L4-L5 and L5-S1 (sacroiliac) level. Treatment to date has included flexeril and percocet. The documentation noted on 6-24-15 the injured worker is on total and temporary disability and her last day of work was on 3-25-13. The original utilization review (8-12-15) non-certified the request for Repeat cervical spine magnetic resonance imaging (MRI) scans without contrast.

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

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

**Repeat cervical spine MRI scan without contrast:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section, MRI cervical spine.

**Decision rationale:** Pursuant to the ACOEM and the Official Disability Guidelines, repeat MRI cervical spine without contrast is not medically necessary. ACOEM states unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients not respond to treatment and who would consider surgery an option. 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 with 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 a computer tomography (CT). The indications for imaging are enumerated in the Official Disability Guidelines. Indications include, but are not limited to, chronic neck pain (after three months conservative treatment), radiographs normal neurologic signs or symptoms present; neck pain with radiculopathy if severe or progressive neurologic deficit; etc. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). The criteria for ordering an MRI of the cervical spine include the emergence of a red flag, physiologic evidence of tissue insult when nerve impairment, failure to progress in a strengthening program intended to avoid surgery and clarification of anatomy prior to surgery. In this case, the injured worker's working diagnoses are lumbago; sciatica; lumbar radiculitis; the generation of lumbar or lumbosacral intervertebral disc; and cervical spondylosis without myelopathy. Date of injury is March 1, 2013. Request for authorization is dated July 30, 2015. The documentation states the injured worker had an MRI cervical spine May 24, 2013. According to a progress note dated July 29, 2015, the worker has ongoing neck and low back pain. Objectively there is paraspinal muscle spasm and tenderness to palpation over the paraspinal muscle groups with decreased range of motion. Repeat MRI is not routinely

recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). There is no documentation of a significant change in symptoms and/or objective findings suggestive of significant pathology. Additionally, there is no neurologic examination of the upper extremities and cervical spine. Based on clinical information and medical records, peer-reviewed evidence-based guidelines, no documentation reflecting a significant change in symptoms and/or objective clinical findings suggestive of significant pathology and an MRI of the cervical spine performed May 24, 2013; repeat MRI cervical spine without contrast is not medically necessary.