

<b>Case Number:</b>	CM15-0044251		
<b>Date Assigned:</b>	03/16/2015	<b>Date of Injury:</b>	10/06/2011
<b>Decision Date:</b>	06/05/2015	<b>UR Denial Date:</b>	02/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/09/2015

### 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, Pain Management

### 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 54 year old male, who sustained an industrial injury on October 6, 2011. He reported pain in his neck, left shoulder and back when moving a cast iron tub. The injured worker was diagnosed as having cervical spine transition syndrome at C3-C4 and C4-C5, left upper extremity radicular pain and paresthesia, lumbar spine disc protrusions, right lower extremity radicular pain and status post anterior cervical decompression and fusion of C5-C7. Treatment to date has included epidural injection, left elbow surgery, medication, TENS unit, imaging of the cervical spine, low back and upper extremities, chiropractic therapy and physical therapy. Currently, the injured worker complains of continuous neck and low back pain. The neck pain radiates to the left upper extremity and into the back and the low back pain is associated with numbness and tingling of the right lower extremity. The treatment plan includes CT of the cervical spine to rule out pseudoarthrosis of C6-C7, MRI of the cervical and lumbar spines to properly diagnose and treat the injured worker, urine drug test, and continuation of home exercise program.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cervical MRI without dye:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 176-177. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter, MRI Topic.

**Decision rationale:** The ACOEM Practice Guidelines, Chapter 8 entitled Neck and Upper Back Complaints specifies on pages 177-182 the following: "For most patients presenting with true neck or upper back problems, special studies are not needed unless a three or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. Criteria for ordering imaging studies are: Emergence of a red flag. Physiologic evidence of tissue insult or neurologic dysfunction. Failure to progress in a strengthening program intended to avoid surgery. Clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. ODG: Neck MRI; 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). In determining whether or not the patient has ligamentous instability, magnetic resonance imaging (MRI) is the procedure of choice, but MRI should be reserved for patients who have clear-cut neurologic findings and those suspected of ligamentous instability. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). (Anderson, 2000) (ACR, 2002) See also ACR Appropriateness Criteria. 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. MRI is the test of choice for patients who have had prior back surgery. (Bigos, 1999) (Bey, 1998) (Volle, 2001) (Singh, 2001) (Colorado, 2001) For the evaluation of the patient with chronic neck pain, plain radiographs (3-view: anteroposterior, lateral, open mouth) should be the initial study performed. Patients with normal radiographs and neurologic signs or symptoms should undergo magnetic resonance imaging. If there is a contraindication to the magnetic resonance examination such as a cardiac pacemaker or severe claustrophobia, computed tomography myelography, preferably using spiral technology and multiplanar reconstruction is recommended. (Daffner, 2000) (Bono, 2007) Indications for imaging -- MRI (magnetic resonance imaging): Chronic neck pain (= after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present. Neck pain with radiculopathy if severe or progressive neurologic deficit. Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present. Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present. Chronic neck pain, radiographs show bone or disc margin destruction. Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal". Known

cervical spine trauma: equivocal or positive plain films with neurological deficit. Upper back/thoracic spine trauma with neurological deficit. Regarding the request for cervical MRI, guidelines support the use of imaging for emergence of a red flag, physiologic evidence of tissue insult or neurologic deficit, failure to progress in a strengthening program intended to avoid surgery, and for clarification of the anatomy prior to an invasive procedure. The ODG further stipulates that repeat imaging should be based upon a significant change in pathology. Under dispute is a repeat cervical MRI with the last study carried out 7/14/14. The provider wishes to rule out pseudoarthrosis given a history of cervical spine surgery. However, a CT cervical spine was simultaneously ordered at the time of the MRI request to evaluate for this pathology. There was no clear documentation of neurologic change at the time of the February 2015 request.

Although there are signs of radiculopathy, there was no full neurologic exam submitted around the time of the prior cervical MRI. In the absence of such documentation, the requested cervical MRI is not medically necessary.

**Lumbar MRI without dye:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**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) Low Back Chapter, MRI Topic.

**Decision rationale:** Regarding the request for repeat lumbar MRI, ACOEM Practice Guidelines do not have specific guidelines on when a repeat study is warranted. In general, lumbar MRI is recommended when there are unequivocal objective findings that identify specific nerve compromise on the neurologic examination in patients who do not respond to treatment and would consider surgery an option. The Official Disability Guidelines state that repeat MRIs should be reserved for cases in which a significant change in pathology has occurred. Within the documentation available for review, there is no identification of any neurologic changes since the last study to necessitate a repeat MRI study. The last lumbar MRI was performed on 7/14/14 and documented multi-level degenerative disc disease and disc bulges. A progress note from 2/9/15 documented sensory loss in the L4-S1 dermatomes on the right, + straight leg raise sign, and 4/5 motor strength in the right leg. There is no complete neurologic exam documented around the time of the last MRI to indicate whether significant progressive objective findings are now noted. Given the lack of documentation regarding any neurologic changes, the currently requested repeat lumbar MRI is not medically necessary.