

Case Number:	CM15-0095007		
Date Assigned:	05/21/2015	Date of Injury:	01/05/2005
Decision Date:	06/30/2015	UR Denial Date:	05/04/2015
Priority:	Standard	Application Received:	05/18/2015

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: 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 57-year-old female, with a reported date of injury of 01/05/2015. The diagnoses include lumbar degenerative anterolisthesis at L4-5, lumbosacral radiculopathy, chronic low back pain, facet mediated back pain, lumbar spondylolisthesis, lumbar spinal stenosis, lumbar degenerative disc disease, anterior cervical pseudoarthrosis and loosened hardware at C5, C5, and C7; cervical fusion from C4-T1 with neck pain, and lower back fusion from L3-S1. Treatments to date have included x-rays of the lumbar spine; an MRI of the lumbar spine on 04/30/2010 which showed facet arthropathy at the L4-5 level; a computerized tomography (CT) scan of the cervical spine on 09/20/2012 which showed loosening of the anterior plate at C7 and ventral displacement of the anterior plate; a CT scan of the lumbar spine on 09/20/2012; oral medications; and cervical spine fusion. The progress report dated 04/22/2015 indicates that the injured worker had ongoing neck pain, which had worsened. She also complained of increased low back pain. The physical examination showed use of a cane, increased range of motion in her neck with tenderness to palpation in the cervicothoracic spine; decreased rotation; pain radiation into the shoulder blade area; a well-healed lumbar incision; some tenderness to palpation of the lumbosacral junction; and some decreased range of motion in the lumbar spine with a positive straight leg raise test on the left. The treating physician requested computerized tomography (CT) scan of the cervical spine to ensure that this had developed an arthrodesis and an MRI of the lumbar spine to rule out adjacent segment disc protrusion or obvious problems.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT (computed tomography) Scan without contrast, Cervical Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179, 181-183. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic), Computed tomography (CT).

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses computed tomography. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints indicates that reliance on imaging studies alone to evaluate the source of neck or upper back symptoms carries a significant risk of diagnostic confusion (false-positive test results). Table 8-8 Summary of Recommendations for Evaluating and Managing Neck and Upper Back Complaints (Page 181-183) indicates that radiography are the initial studies when red flags for fracture, or neurologic deficit associated with acute trauma, tumor, or infection are present. CT may be recommended to evaluate red-flag diagnoses. Imaging is not recommended in the absence of red flags. CT may be recommended to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) indicates that computed tomography (CT) is not recommended except for indications below. 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. MRI or CT imaging studies are valuable when 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. 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. Repeat CT 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 where MRI is contraindicated). The progress report dated January 19, 2015 documented 1/19/15 X-rays AP anteroposterior and lateral of the cervical spine are obtained. These show evidence of good position of the posterior segmental hardware from C4 through T1. No hardware loosening. The interbody cages are in good position. There are no signs of failure. AP anteroposterior and lateral views of the cervical spine show good alignment and position of the cervical hardware with early improvement in bone consolidation noted. No evidence of hardware loosening was documented. The progress report dated March 4, 2015 documented that X-rays, AP and lateral

cervical x-rays taken March 4, 2015, which showed good alignment and position of hardware from C4 to T1 with no evidence of hardware failure. There is improved bone consolidation. The progress report dated April 22, 2015 documented that the physical examination showed that the patient has some increased range of motion in her neck with tenderness to palpation in the cervicothoracic spine. She has decreased rotation. The patient has pain radiating into the shoulder blade area. X-rays performed on 4/22/15 demonstrated a solid cervical fusion from C4 through T1. No hardware problems were seen. Diagnoses was cervical fusion from C4 through T1 with neck pain. The patient continues to have neck pain. The physician requested a CT scan of the neck. No neurological deficit was documented in the 4/22/15 physical examination. X-rays of the cervical spine were performed on 1/19/15, 3/4/15, and 4/22/15, which were reviewed by the treating physician who reported that the X-rays demonstrated no abnormalities. ACOEM indicates that imaging is not recommended in the absence of red flags. Official Disability Guidelines (ODG) indicates that computed tomography (CT) is not recommended except for indications below. In determining whether or not the patient has ligamentous instability, magnetic resonance imaging (MRI) is the procedure of choice. MRI is the test of choice for patients who have had prior back surgery. Patients with normal radiographs and neurologic signs or symptoms should undergo magnetic resonance imaging. MTUS, ACOEM, ODG guidelines do not support the request for a cervical spine CT computed tomography. Therefore, the request for CT scan of the cervical spine is not medically necessary.

MRI (magnetic resonance imaging) without contrast, Lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - MRIs (magnetic resonance imaging).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304, 308-310.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses magnetic resonance imaging MRI of the lumbosacral spine. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints states that relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false-positive test results). Table 12-8 Summary of Recommendations for Evaluating and Managing Low Back Complaints (Page 308- 310) recommends MRI when cauda equina, tumor, infection, or fracture are strongly suspected and plain film radiographs are negative. The progress report dated March 4, 2015 documented that the patient has a remote history of lumbar fusion. Previous CT computed tomography scans have revealed a solid-appearing fusion at L3 to S1. Computed tomography CT of the lumbar spine post myelogram was performed on September 20, 2012. At L4-5, there is a 1 mm anterolisthesis of L4 with respect to L5. There is moderate facet hypertrophy. These findings minimally narrow the canal. There is minimal foraminal narrowing. At L3-4, there is a slight 2 to 3 mm disk bulge and mild facet hypertrophy with a mild component of epidural lipomatosis which mildly narrows the canal. There is no significant foraminal stenosis. The progress report dated April 22, 2015 documented that the patient continues to have lower back pain. The physician requested an MRI scan of the lower back to rule out adjacent segment disk protrusion or obvious problems. The progress report dated April 22, 2015 documented that the physical examination showed that the patient has tenderness in the right knee prepatellar area. She has tenderness to palpation at the left knee joint line. The patient has a well-healed lumbar

incision. The patient has some tenderness to palpation at the lumbosacral junction and some decreased range of motion in the lumbar spine with a positive straight leg raise on the left at 90 degrees sitting, negative on the right. X-rays were performed on 4/22/15. AP anteroposterior and lateral lumbar spine X-rays 4/22/15 show a solid fusion from L3 through S1. The adjacent segment shows no major changes. Diagnosis was lower back fusion from L3 through S1, stable by X-ray. No neurological deficit was documented in the 4/22/15 physical examination. ACOEM indicates that imaging is not recommended in the absence of red flags. No evidence of cauda equina, tumor, infection, or fracture was documented. Therefore, the request for lumbar MRI magnetic resonance imaging is not supported by MTUS guidelines. Therefore, the request for MRI of the lumbar spine is not medically necessary.