

<b>Case Number:</b>	CM13-0035944		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	04/04/2010
<b>Decision Date:</b>	10/07/2015	<b>UR Denial Date:</b>	10/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/18/2013

### 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, District of Columbia,  
Maryland Certification(s)/Specialty: Anesthesiology, 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:

This 44 year old female sustained an industrial injury to the low back, neck and right shoulder on 4-4-10. Electromyography of bilateral upper extremities (5-30-13) was normal. Previous treatment included magnetic resonance imaging right shoulder (5-3-13), magnetic resonance imaging cervical spine (5-3-13), physical therapy, chiropractic therapy, acupuncture, home exercise and medications. In a pain management follow up evaluation dated 9-5-13, the injured worker complained of neck and shoulder pain rated 8 out of 10 on the visual analog scale. The injured worker stated that medications helped relieve her pain. Physical exam was remarkable for cervical spine with tenderness to palpation and spasm over the paraspinal extending to the trapezius with positive right Axial head compression and Spurling's sign and decreased lateral flexion and rotation, tenderness to palpation over the facets at C4-7 and lumbar spine with facet tenderness at L4-S1, tenderness to palpation over the lumbar paraspinal musculature with positive right straight leg raise, decreased range of motion, 5 out of 5 bilateral lower extremity strength and decreased sensation along the right L4-5 distribution. Current diagnoses included cervical disc disease, cervical spine radiculopathy, right shoulder tendonitis and lumbar spine sprain and strain. The treatment plan included requesting authorization for a right C6-7 medial branch block, a new magnetic resonance imaging of the lumbar spine, lower extremity electromyography and nerve conduction velocity test, a refill of Vicodin and urine toxicology screening.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI (Magnetic Resonance Imaging) of the lumbar spine without contrast:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, MRIs (Magnetic resonance imaging).

**Decision rationale:** Per the ODG guidelines with regard to MRI of the lumbar spine: Recommended for indications below. MRI's are test of choice for patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy, not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. 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). (Bigos, 1999) (Mullin, 2000) (ACR, 2000) (AAN, 1994) (Aetna, 2004) (Airaksinen, 2006) (Chou, 2007) Magnetic resonance imaging has also become the mainstay in the evaluation of myelopathy. An important limitation of magnetic resonance imaging in the diagnosis of myelopathy is its high sensitivity. Indications for imaging, Magnetic resonance imaging: Thoracic spine trauma: with neurological deficit, Lumbar spine trauma: trauma, neurological deficit, Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit), Uncomplicated low back pain, suspicion of cancer, infection, other "red flags", Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. Uncomplicated low back pain, prior lumbar surgery, Uncomplicated low back pain, cauda equina syndrome, Myelopathy (neurological deficit related to the spinal cord), traumatic, Myelopathy, painful, Myelopathy, sudden onset, Myelopathy, stepwise progressive, Myelopathy, slowly progressive, Myelopathy, infectious disease patient, Myelopathy, oncology patient, Repeat MRI: When there is significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). Per the medical records, there was facet tenderness at L4-S1, tenderness to palpation over the lumbar paraspinal musculature with positive right straight leg raise, decreased range of motion, 5/5 bilateral lower extremity strength, and decreased sensation along the right L4-L5 distribution. Per citation above, uncomplicated low back pain with radiculopathy, after at least 1 month conservative therapy is an indication for MRI. The request is medically necessary.