

<b>Case Number:</b>	CM13-0003105		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	05/29/2005
<b>Decision Date:</b>	02/27/2014	<b>UR Denial Date:</b>	07/05/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/25/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine, and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 64 year old male with at DOI of 6/19/2005. The patient twisted his ankle and fell. MRI cervical spine 8/29/13 showed postsurgical change C5-7 with anterior plate and screws, moderate disc height loss from C3-4 through C6-7, thecal sac effacement oat C5-6 and C6-7. Multilevel moderate severe neural foraminal narrowing from C3-4 through C6-7. Worse at right foramina of C5-6 and C6-7. MRI cervical spine 2/9/2011 showed 3-4mm R>L broad disc protrusion at C5-6 resulting in severe foraminal encroachment. MRI cervical spine 11/5/2009: cord compression with myelomalacia at C5-6 and C6-7 MRI cervical spine 11/5/2008,: central stenosis, C5-6 C6-7 myelomalacia with severe right foraminal stenosis at C5-6 and C6-7 The patient had ESI on 3/7/13 with pain relief > 70% and improve mobility, which is reportedly wearing off. The patient had 12 sessions of therapy with a psychologist as of 10/2013. The patient is s/p decompression on 5/6/11 and diagnosed with right C5-6, C6-7 radiculopathy. He also has issues with CTS, epicondylitis, his hip, knees and lumbar spine. The patient is pending treatment for a possible inguinal hernia. The patient continues to have pain in the neck with radiation into the shoulders and upper arms.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 single positional MRI of the cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177.

**Decision rationale:** There is no indication in the RFA progress note indicating a need for a repeat MRI of the cervical spine. There is no change in symptoms from the previous MRI at the time of the request. There are no new red flag signs, indication for additional procedures, or failure in progression of a new treatment. MTUS recommends on page "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 neuro- logic examination are sufficient evidence to warrant imaging studies if symp- toms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study." At the time of this IMR request there was no medical need for a repeat MRI of the cervical spine.