

<b>Case Number:</b>	CM13-0005213		
<b>Date Assigned:</b>	03/03/2014	<b>Date of Injury:</b>	01/04/2003
<b>Decision Date:</b>	04/14/2014	<b>UR Denial Date:</b>	07/24/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/30/2013

### 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. The expert 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 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/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:

According to the records made available for review, this is a 70-year-old female with a 1/4/03 date of injury. At the time (7/11/13) of request for authorization for Magnetic resonance imaging (MRI) Of The Cervical Spine Without Contrast And Retrospective X-Rays Of the Cervical Spine For DOS 7/11/2013, there is documentation of subjective (neck pain with radiating bilateral extremity pain and headaches) and objective (tenderness over the paracervical muscles, diminished cervical range of motion, diminished reflexes in the bilateral brachioradialis, and sensory deficit at the bilateral C5 and C6 dermatomal distributions) findings, imaging findings ( Reported Magnetic resonance imaging (MRI) Cervical Spine (8/31/12) revealed at C6-7 tjer eos a 6.6 mm posterior disc herniation causing severe spinal canal stenosis and mild bilateral foraminal stenosis, at C3-4, there is a 4.5 mm posterior disc protrusion with mild spinal canal stenosis, at C4-5 there is a 4.5 mm posterior disc protrusion with mild spinal canal stenosis, and at C5-6 there is a right uncovertebral joint hypertrophy causing mild right foraminal stenosis; report not available for review; X-ray Cervical Spine), current diagnoses (C4-7 disc degeneration, bilateral cervical radiculopathy, bilateral lumbar radiculopathy, C4-7 stenosis, and L4-S1 stenosis), and treatment to date (medications). Discussion indicates a recommendation for an updated Magnetic resonance imaging (MRI) of the Cervical Spine and updated X-rays. There is no documentation of a diagnosis/condition (with supportive subjective/objective findings) that would support a repeat study.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MAGNETIC RESONANCE IMAGING (MRI) OF THE CERVICAL SPINE WITHOUT CONTRAST:** 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): 179-180. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) reference to American College of Occupational and Environmental Medicine (ACOEM) guidelines identifies documentation of red flag diagnoses where plain film radiographs are negative; objective findings that identify specific nerve compromise on the neurologic examination, failure of conservative treatment, and who are considered for surgery, as criteria necessary to support the medical necessity of Magnetic Resonance Imaging (MRI). Official Disability Guidelines (ODG) identifies documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (such as: To diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings) as criteria necessary to support the medical necessity of a repeat Magnetic Resonance Imaging (MRI). Within the medical information available for review, there is documentation of diagnoses of C4-7 disc degeneration, bilateral cervical radiculopathy, bilateral lumbar radiculopathy, C4-7 stenosis, and L4-S1 stenosis. In addition, there is documentation of a previous Magnetic Resonance Imaging (MRI) of the cervical spine. However, despite documentation of a recommendation for an updated cervical Magnetic Resonance Imaging (MRI), there is no documentation of a diagnosis/condition (with supportive subjective/objective findings) that would support a repeat study. Therefore, based on guidelines and a review of the evidence, the request for Magnetic Resonance Imaging (MRI) of the Cervical Spine without contrast is not medically necessary.

**RETROSPECTIVE X-RAYS OF THE CERVICAL SPINE FOR DOS 7/11/2013:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)- NECK AND UPPER BACK, PAGES 165, 178

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) reference to American College of Occupational Medicine (ACOEM) guidelines identifies documentation of red flags for fracture, or neurologic deficit associated with acute trauma, tumor, or infection, as criteria necessary to support the medical necessity of radiographs. Official Disability Guidelines (ODG) identifies documentation of a diagnosis/condition (with supportive subjective/objective findings)

for which a repeat study is indicated (such as: To diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings) as criteria necessary to support the medical necessity of a repeat X-rays. Within the medical information available for review, there is documentation of diagnoses of C4-7 disc degeneration, bilateral cervical radiculopathy, bilateral lumbar radiculopathy, C4-7 stenosis, and L4-S1 stenosis. In addition, there is documentation of a previous X-ray of the cervical spine. However, despite documentation of a recommendation for updated cervical x-rays, there is no documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated. Therefore, based on guidelines and a review of the evidence, the request for Retrospective X-rays of the Cervical Spine for DOS 7/11/2013 is not medically necessary.