

<b>Case Number:</b>	CM13-0047901		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	04/03/2009
<b>Decision Date:</b>	02/26/2014	<b>UR Denial Date:</b>	10/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/04/2013

### 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 Physical Medicine and Rehabilitation and is licensed to practice in New York and Texas. 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 61-year-old female who reported an injury on 04/03/2009. The mechanism of injury was a punch in the neck. The patient is status post anterior cervical fusion in 2009. The patient is status post cervical laminectomy at C4 through C7 in 2011. The patient reported she has good days and bad days. The patient reported that she had an episode where she was slurring her speech, was unable to stand without assistance and her eyes were glassy. She was not aware of the symptoms, but told to her by her family members. The patient reported she continues to balance issues but denies any dizziness. The patient had a previous MRI of the cervical spine on 07/23/2013. The MRI showed posterior and anterior fusion in the lower cervical spine. Myelomalacia involving the cervical cord and the lower cervical areas was noted. The findings had changed significantly from the previous examination. This MRI was compared to an MRI scan dated 02/16/2012. There was no evidence of any cord compression in the entire cervical axis, but the myelomalacia was present especially in the posterior columns of the cervical spinal cord and it seemed to have the length of about 1 cm. This was believed to be consistent with the prior acute herniated cervical disc with impaction against the cord previous industrial injury. The patient had an MRI of the brain which showed a very small aneurysm at 50%: non-operative at this time, but needs to be followed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of the Cervical Spine Qty 1.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter, MRI

**Decision rationale:** Official Disability Guidelines state 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). The patient reported she is okay but continued to have balance issues. The clinical documentation submitted for review does not show medical necessity at this time. The documentation submitted did not indicate a change in the patient's symptoms to support and MRI. Given the lack of documentation to support guideline criteria, the request is non-certified.