

<b>Case Number:</b>	CM13-0058170		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	03/20/2001
<b>Decision Date:</b>	04/30/2014	<b>UR Denial Date:</b>	11/19/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/26/2013

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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:

This patient is a 58-year-old male with date of injury of 03/20/2001. Per treating physician's report, 07/10/2013, presenting symptoms include neck and low back pain that is 7/10 to 8/10, with bilateral upper extremity numbness and tingling to the triceps as well as right lower extremity numbness, tingling, and pain extending down to the foot. Examination showed tenderness over the cervical, thoracic, and lumbar paraspinals, anterior cervical site over the cervical spine well-healed without any signs of infection. Listed diagnoses are: Anterior cervical decompression and fusion at C6-C7, lumbar fusion at L4-L5 and L5-S1, bilateral S1 radiculopathy per EMG, bilateral total hip replacements. Request for authorization include MRI of the cervical spine. It would appear that the patient went ahead and had the MRI of the cervical spine performed on 07/24/2013. Report from 05/03/2013 discusses that the patient had anterior cervical decompression and fusions at C6-C7 by [REDACTED] as well as lumbar fusion at L4-L5 and L5-S1 by [REDACTED]. The patient's last MRI and x-rays were over 2 years ago. This report does not provide a date of these surgeries. He reviewed the x-rays which were taken on that day that showed solid fusion at C6-C7 with spondylolisthesis at C5-C6 with multilevel neuroforaminal narrowing.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI OF CERVICAL SPINE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (Odg), Neck And Upper Back Procedure Summary

**MAXIMUS guideline:** Decision based on MTUS ACOEM Page(s): 177, 178.

**Decision rationale:** This patient presents with chronic neck and low back pain. The patient has some radiating symptoms in the upper extremity into the triceps. The request is for MRI of the cervical spine. Review of the reports show that this patient underwent cervical discectomy and fusion at C6-C7 sometime in the past. None of the reports reviewed by the treating physicians indicate when this surgery was done. X-rays obtained for 05/03/2013 showed solid fusion at C6-C7 with spondylolisthesis at C5-C6. ACOEM Guidelines recommend special imaging studies for emergence of red flag, physiologic evidence of tissue insult and neurologic dysfunction, et cetera. ACOEM Guidelines may not apply as this patient has chronic pain. ODG Guidelines recommends MR imaging when neurologic signs or symptoms are present. In this patient, the treating physician does not provide any rationale for obtaining an MRI. This patient has had surgery in the past and updated MRI may be warranted. However, there are no documentations of any significant changes from the patient's symptoms. There are no new injuries or aggravations. There are no changes in neurologic examination. Without significant changes in neurologic signs or symptoms, an updated MRI is not necessary. The treating physician also does not mention when the patient's surgery was to understand the timeframe. X-ray would indicate a solid fusion and thus, spine surgery may have been a number of years ago. Therefore, the key issues would be whether or not there have been significant changes or progression of neurologic findings. In this case, the treating physician does not provide any such documentation. Recommendation is for denial.