

<b>Case Number:</b>	CM14-0047163		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	06/15/2013
<b>Decision Date:</b>	08/01/2014	<b>UR Denial Date:</b>	03/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/15/2014

### 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:

The claimant injured her cervical spine on 08/15/13. An MRI of the cervical spine is under review. She underwent physical therapy with some minor improvement. She also received acupuncture. She had an MRI of the right shoulder on 11/12/13 that showed AC osteoarthritis and tendinitis of the rotator cuff. An MRI of the cervical spine was done on 01/10/14 that showed mild disc bulging at multiple levels from C3-C7. There was foraminal stenosis noted at multiple levels most severe at C5-6 and C6-7. She has continued complaining of neck pain. She has positive Finkelstein's as well as positive Tinel's and Phalen's on examination. She also had diminished sensation in multiple nerve root distributions from C5 to T1. She had weakness in the upper extremities. No reflex deficits were identified. There is been no evidence to support new or progressive neurologic deficits. On 03/17/14, she saw [REDACTED] for an AME. She was status post therapy for her neck. She stated that [REDACTED] was recommending injections to her neck and low back. She complained of tenderness in the neck but there was no spasm. Axial compression test was painless. Spurling's test was negative. She had good range of motion. She was diagnosed with a chronic cervical sprain superimposed upon spondylosis and degenerative disc disease with findings at multiple levels on an MRI. Her findings included non-verifiable radicular complaints. She was given an impairment rating. She also had an evaluation by [REDACTED] for PM&R consultation and electrodiagnostic studies on 02/10/14. She reported burning and aching neck pain radiating to the bilateral upper extremities. The pain was relieved with heat, hot baths, and walking. Cervical spine was normal with some tenderness to palpation. She had tenderness in the bilateral elbows, wrists, and shoulders. Neurologic examination was intact. There was evidence of median neuropathy that was bilateral and slightly worse on the left side and ulnar neuropathy.

## 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:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 177-179.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**Decision rationale:** The history and documentation do not objectively support the request for a repeat MRI in the absence of clear evidence of new or progressive neurologic deficits and/or failure of a reasonable course of conservative treatment. The California MTUS state 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 or 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 neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. In this case, the claimant had electrodiagnostic studies and there was no evidence of radiculopathy. The specific indication for a repeat study has not been clearly described and none can be ascertained from the records. The claimant's history of evaluation and course of treatment to date have not been clearly documented. The medical necessity of this study has not been demonstrated.