

<b>Case Number:</b>	CM15-0166239		
<b>Date Assigned:</b>	09/03/2015	<b>Date of Injury:</b>	03/15/2010
<b>Decision Date:</b>	10/06/2015	<b>UR Denial Date:</b>	08/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/24/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Arizona, California

Certification(s)/Specialty: Family Practice

### 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 47 year old male sustained an industrial injury to the neck and back on 3-15-10. Previous treatment included cervical fusion (2011), lumbar laminectomy at L4-5 (2012), physical therapy, epidural steroid injections, injections, home exercise and medications. Magnetic resonance imaging cervical spine (4-9-14) showed evidence of cervical spine fusion at C4-6, with disc desiccation and protrusions at C3-4 and C6-7 and. Magnetic resonance imaging lumbar spine (6-22-15) showed canal stenosis with neural foraminal narrowing and levoscoliosis with retrolisthesis at L3-4 and L4-5. X-rays lumbar spine (5-7-15) showed multilevel osteophytes and disc space narrowing at L5-S1 and L4-5. In a PR-2 dated 8-4-15, the injured worker complained of increased neck pain with radiation to bilateral upper extremities associated with numbness, tingling and headaches and increased low back pain with radiation to bilateral lower extremities. The injured worker rated his pain 10 out of 10 on the visual analog scale without medications and 7 out of 10 with medications. Physical exam was remarkable for cervical spine with diffuse tenderness to palpation and restricted range of motion and lumbar spine with diffuse tenderness to palpation, positive bilateral straight leg raise and decreased range of motion. Current diagnoses included lumbar spine intervertebral disc displacement without myelopathy, obesity, cervicgia, lumbar post laminectomy syndrome, cervical spine intervertebral disc displacement, brachial neuritis, lumbar spine radiculitis and cervical spine degenerative disc disease. The physician stated that the injured worker's neck and arm symptoms had taken a turn for the worse. The injured worker was experiencing headaches. The physician noted that the injured worker's previous cervical spine magnetic resonance imaging had become progressively

outdated from an interventional standpoint. A new magnetic resonance imaging was required prior to considering further interventional treatment. The treatment plan included a cervical spine magnetic resonance imaging, continuing home exercise, continuing medications (Roxicodone, Norco and Soma), requesting authorization for a psychiatric consultation and sleep study, awaiting authorization for a spinal cord stimulator trial with psychological clearance, scheduling, and proceeding with caudal epidural steroid injections.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Cervical MRI:** 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): 182.

**Decision rationale:** According to the ACOEM guidelines, an MRI of the cervical spine is not recommended in the absence of any red flag symptoms. It is recommended to evaluate red-flag diagnoses including tumor, infection, fracture or acute neurological findings. It is recommended for nerve root compromise in preparation for surgery. There were no red flag symptoms. In this case, the claimant had an MRI a year ago. The plan was for another ESI, which may not be indicated. There was mention of a neurosurgeon consultation, but the requesting physician did not feel that surgery was needed. The request for another MRI of the cervical spine is not medically necessary.