

<b>Case Number:</b>	CM15-0193120		
<b>Date Assigned:</b>	10/07/2015	<b>Date of Injury:</b>	08/08/2013
<b>Decision Date:</b>	11/13/2015	<b>UR Denial Date:</b>	09/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/01/2015

### 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 is a 62 year old male with a date of injury of August 8, 2013. A review of the medical records indicates that the injured worker is undergoing treatment for cervical stenosis, cervical herniated nucleus pulposus, and cervical radiculopathy. Medical records dated August 27, 2015 indicate that the injured worker complained of increased pain in the neck rated at a level of 8 out of 10 that radiates to the bilateral upper extremities worse on the right. A progress note dated September 10, 2015 documented complaints of constant neck pain and tingling right greater than left, increased pain with range of motion, radiating tingling down the bilateral upper extremities, numbness from the elbows to the finger tips, persistent headaches, pain rated at a level of 8 out of 10, and decreased sensation in the fingertips. Per the treating physician (September 10, 2015), the employee had activity restrictions that included no lifting, pushing, or pulling greater than five pounds, no repetitive lifting, pushing, or pulling, and limit overhead activity to rare. The physical exam dated August 27, 2015 reveals decreased range of motion of the cervical spine, decreased sensation at the left C5 and C8 dermatomes, and neck pain with Spurling's maneuver. The progress note dated September 10, 2015 documented a physical examination that showed diffuse tenderness to palpation over the cervical spine midline and bilateral cervical paraspinals and trapezius muscles, positive Spurling's maneuver bilaterally right greater than left, decreased range of motion of the cervical spine, and decreased sensation in the right C5, C6, and C7 dermatomes to light touch. Treatment has included physical therapy, chiropractic treatments, medications, and magnetic resonance imaging of the cervical spine (July 29, 2014) that showed disc desiccation at C2-3 to C6-7, reduced intervertebral disc height

at C5-6, Modic Type II endplate degenerative changes at C5-6, diffuse disc protrusion effacing the thecal sac at C2-3 with narrowing of the left neural foramen that effaces the left C3 exiting nerve root, focal central disc protrusion effacing the thecal sac at C3-4 with bilateral neural foraminal narrowing that effaces the left and right C4 exiting nerve roots, diffuse disc protrusion effacing the thecal sac at C4-5, diffuse disc protrusion effacing the thecal sac at C5-6 with bilateral neural foraminal stenosis that encroaches the left and right C6 exiting nerve roots, focal central disc extrusion with annular tear indenting the thecal sac and spinal cord at C6-7 with bilateral neural foraminal stenosis that encroaches the left and right C7 exiting nerve roots, peridiscal osteophytes on both sides and posterior osteophytes at C7-T1 along with hypertrophy of the facet joints and uncinata process causing spinal canal narrowing and neural foraminal narrowing on both sides, and grade I retrolisthesis of C4 over C5 and C6 over C7. The original utilization review (September 25, 2015) non-certified a request for magnetic resonance imaging of the cervical spine.

### **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 Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chapter: Neck and Upper Back (Acute & Chronic) Magnetic resonance imaging (MRI).

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Summary.

**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. There was no plan for surgery. The last MRI was within the year. There is no indication that a more recent MRI is required for an ESI. There was already evidence of prior MRI showing nerve root effacement from C4-C6. The request for an MRI of the cervical spine is not medically necessary.