Case Number:	CM15-0195956		
Date Assigned:	10/09/2015	**Date of Injury:**	04/15/2010
Decision Date:	11/18/2015	**UR Denial Date:**	09/18/2015
Priority:	Standard	**Application Received:**	10/05/2015

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: Montana
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 injured worker is a 52 year old male who sustained an industrial injury on 04-15-2010. On 05-21-2013 MRI of the cervical spine revealed degenerative disc disease with disc herniation at C5-6 and C6-7 superimposed upon multilevel prominent disc bulges. According to a progress report dated 08-25-2015, the injured worker had chronic neck and low back pain. Pain was "severe" at times. It appeared to be worsening. Neck was supple with free range of motion. Pain when leaning forward was noted. Trigger points were noted. Pain to palpation at midline, paraspinal area and lateral lumbar tenderness with palpation was noted. Diagnoses included cervical disc degeneration and lumbosacral spondylosis. The treatment plan included MRI of the cervical spine, left and right knee and lumbar spine. Follow up was indicated in 4 weeks. A previous examination of the cervical spine on 06-22-2015 noted tenderness, decreased flexion, extension, rotation, left lateral bending and right lateral bending. An authorization request dated 08-25-2015 was submitted for review. The requested services included cervical MRI, left knee MRI, right knee MRI and lumbar MRI. On 09-18-2015, Utilization Review non-certified the request for MRI 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: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 2015, Neck Chapter, Magnetic Resonance Imaging.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck, Magnetic resonance imaging (MRI).

Decision rationale: The MTUS in the ACOEM guidelines states that for most patients presenting with true neck or upper back problems, special studies are not needed unless a 3 or 4 week period of conservative care and observation fails to improve symptoms. Most patients improve quickly provided any red-flag conditions are ruled out. Criteria for ordering imaging studies are emergence of a red flag condition, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery and clarification of the anatomy prior to invasive procedures. An imaging study may be appropriate for a patient who's limitations due to consistent symptoms have persisted for 4-6 weeks or more, when surgery is being considered for a specific anatomic defect or to further evaluate the possibility of potentially serious pathology, such as a tumor. Reliance on imaging studies alone to evaluate the source of neck or upper back symptoms carries a significant risk of diagnostic confusion (false-positive test results) because it's possible to identify a finding that was present before symptoms began and therefore has no temporal association with the symptoms. The ODG Guidelines note that cervical MRI is not recommended except for indications listed below. In determining whether or not the patient has ligamentous instability, magnetic resonance imaging (MRI) is the procedure of choice, but MRI should be reserved for patients who have clear-cut neurologic findings and those suspected of ligamentous instability. MRI imaging studies are valuable when physiologic evidence indicates tissue insult or nerve impairment or potentially serious conditions are suspected like tumor, infection, and fracture, or for clarification of anatomy prior to surgery. For the evaluation of the patient with chronic neck pain, plain radiographs (3-view: anteroposterior, lateral, open mouth) should be the initial study performed. Patients with normal radiographs and neurologic signs or symptoms should undergo magnetic resonance imaging. Indications for imaging, MRI (magnetic resonance imaging): Chronic neck pain (after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present; Neck pain with radiculopathy if severe or progressive neurologic deficit; Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present; Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present; Chronic neck pain, radiographs show bone or disc margin destruction; Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal"; Known cervical spine trauma: equivocal or positive plain films with neurological deficit; Upper back/thoracic spine trauma with neurological deficit. 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). (Anderson, 2000) (ACR, 2002) In this case the medical records do not provide report of initial radiographic imaging. The recent clinical evaluations from 4-21-15 to 8-25-15 do not show that the injured worker has severe or progressive neuropathy or evidence for significant pathology as noted above. There are no neurologic findings on examination. The request for magnetic resonance imaging of the cervical spine is not consistent with the MTUS and ODG guidelines and is not medically necessary.