

<b>Case Number:</b>	CM15-0209646		
<b>Date Assigned:</b>	10/28/2015	<b>Date of Injury:</b>	12/15/1995
<b>Decision Date:</b>	12/09/2015	<b>UR Denial Date:</b>	10/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/25/2015

### 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: Texas, Florida, California

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:

This is a 56-year-old male with a date of industrial injury 12-15-1995. The medical records indicated the injured worker (IW) was treated for cervicgia; postlaminectomy syndrome; and anesthesia of the skin. In the 8-21-15 and 10-9-15 notes, his complaints were similar, with constant pain in the neck rated 4 out of 10. He also had pain and numbness in the right arm with tingling into the fingers and numbness in the left forearm from the elbow to the hand and involving the left hand. On examination (8-21-15 notes), there was soreness to palpation of the neck. Forward flexion of the cervical spine was 40 degrees, extension 30 degrees and rotation left and right was 45 degrees. Muscle strength was 5 out of 5 throughout the neck, shoulders, elbows and wrists. Deep tendon reflexes in the bilateral upper extremities were "decreased" and radial pulses were 1+ bilaterally. He denied numbness and tingling on examination on 8-21-15. He stated the "occasional" numbness in the fingers and hands was getting worse, as was his neck pain. Treatments included physical therapy (unsure if this was helpful, per the 10-9-15 notes). The IW was working full duty. The 8-21-15 notes stated there was no history of a previous MRI. The provider recommended an open MRI of the cervical spine due to previous cervical spine surgery, increased symptoms and lack of response to physical therapy. The records did not specify how much physical therapy the IW had attended. A Request for Authorization was received for an MRI of the cervical spine. The Utilization Review on 10-16-15 non-certified the request for an 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:** 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 and Upper Back (Acute and Chronic), MRI.

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

**Decision rationale:** Although there is subjective information presented in regarding increasing pain, there are no accompanying changes in objective physical neurological signs. The case would therefore not meet the MTUS-ACOEM criteria for cervical magnetic imaging, due to the lack of objective, unequivocal neurologic physical examination findings documenting either a new radiculopathy, or a significant change in a previously documented radiculopathy. The guides state: Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminate imaging will result in false positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. The request is not medically necessary.