

<b>Case Number:</b>	CM15-0219301		
<b>Date Assigned:</b>	11/12/2015	<b>Date of Injury:</b>	02/10/2012
<b>Decision Date:</b>	12/29/2015	<b>UR Denial Date:</b>	10/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/06/2015

### 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: California, District of Columbia, Maryland  
 Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 49 year old male, who sustained an industrial injury on February 10, 2012. The injured worker was diagnosed as having status post slip and fall backwards resulting in head contusion, concussion, and positive loss of consciousness on February 10, 2012, status post work injury in 2007, cervical spine pain with cervical radiculopathy from 2007 injury, cervical 5 to 6 and cervical 6 to 7 moderate canal stenosis and mild flattening of the cord per magnetic resonance imaging on April 07, 2014, lumbar spine pain "probably" from injury in 2007, post traumatic headaches "probably" from injury of 2007, sleeping difficulties with abnormal sleep testing, short term memory and concentration difficulties, blurry vision and tinnitus, and history of seizures and cavernous hemangioma with status post brain surgery in 1979 that was non-industrial. Treatment and diagnostic studies to date has included medication regimen, cervical magnetic resonance imaging performed on April 07, 2014, sleep testing, and neuropsychological testing. In a progress note dated September 14, 2015 the treating physician reports complaints of daily headaches with photophobia, nausea, and numbness at the trauma site, along with cognitive impairment, short-term memory and concentration issues, and sleep impairment per neurology qualified medical examination on September 16, 2014. On September 14, 2015 the treating physician noted an examination that was revealing for numbness at cervical 8 distribution to the left upper extremity, numbness to the lumbar 5 distribution of the left lower extremity, an antalgic gait favoring the left leg, tenderness to the occipital region, spasms to the lumbar and cervical muscles, and tenderness to the cervical and lumbar spine per neurology examination on September 16, 2014. On September 14, 2015 the treating physician

requested repeat magnetic resonance imaging of the cervical spine, but did not indicate the specific reason for the requested magnetic resonance imaging however, the Qualified Medical Re-evaluation on July 13, 2015 noted a request for a repeat magnetic resonance imaging of the cervical spine for symptoms of cervical radiculopathy. On October 09, 2015 the Utilization Review determined the request for repeat magnetic resonance imaging of the cervical spine to be non-certified.

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

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

### **Repeat cervical MRI: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck, MRI.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Magnetic resonance imaging (MRI).

**Decision rationale:** Per the ODG guidelines with regard to MRI of the lumbar spine: Not recommended except for indications list below. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, and have no neurologic findings, do not need imaging. Patients who do not fall into this category should have a three-view cervical radiographic series followed by computed tomography (CT). 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. 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) See also ACR Appropriateness Criteria. 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. MRI is the test of choice for patients who have had prior back surgery. (Bigos, 1999) (Bey, 1998) (Volle, 2001) (Singh, 2001) (Colorado, 2001) 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. If there is a contraindication to the magnetic resonance examination such as a cardiac pacemaker or severe claustrophobia, computed tomography myelography, preferably using spiral technology and multiplanar reconstruction is recommended. (Daffner, 2000) (Bono, 2007) 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 MRI of the cervical spine dated 4/7/14 revealed C5-C6 and C6-C7 moderate central canal stenosis and mild flattening of the cord. Per physical exam dated 9/16/15, numbness in the C8 distribution of the left upper extremity, numbness in the L5 distribution of the left lower extremity, an antalgic gait favoring the left leg, some tenderness over the occiput symmetrically, mild muscle spasms in the cervical and lumbar spine, and tenderness over the cervical and lumbar spine which is more severe on the left than right were noted. I respectfully disagree with the UR physician, the medical records do contain a change in symptoms including numbness in the C8 distribution which supports the role of repeat MRI. The request is medically necessary.