

<b>Case Number:</b>	CM15-0221498		
<b>Date Assigned:</b>	11/17/2015	<b>Date of Injury:</b>	07/27/2011
<b>Decision Date:</b>	12/30/2015	<b>UR Denial Date:</b>	11/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/11/2015

### 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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 7-27-11. He is not working. Medical records indicate that the injured worker has been treated for posttraumatic head syndrome; cervical radiculitis; cervicogenic headache; cervical myofascitis. He currently (10-13-15) complains of constant neck pain extending down the upper extremity on the right; headaches; right sided face and eye pain; tingling pain radiating into right shoulder; gastritis secondary to medication; severe daytime somnolence. Physical exam revealed continuous, constant tightness in the cervical region increased with deep palpation, weakness of biceps and wrist flexors on the right with decreased biceps and triceps reflexes on the right. Per 10-8-15, note symptoms radiate in a C7 distribution on the right and his pain level was 7 out of 10. Diagnostics include MRI of the cervical spine (4-29-14) showing moderate central stenosis at C5-6; diffuse congenital narrowing of cervical spine, multilevel neuroforaminal narrowing C4-5, C5-6 on the right. Treatments to date include cervical epidural steroid injection (7-27-15) with 100% relief for a day and a half and then symptoms became much worse; medication: Norco, Nucynta, Percocet, Ultram, Fioricet, gabapentin, omeprazole, Buspar, Seroquel; chiropractic manipulation. The request for authorization dated 10-22-15 was for MRI of the cervical spine. On 11-2-15 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 cervical spine without contrast: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004.

**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 and Upper Back (acute and chronic) Chapter, under Magnetic Resonance Imaging.

**Decision rationale:** The 52-year-old patient complains of neck pain radiating to right upper extremity and right shoulder, daily headaches, right-sided face and eye pain, gastritis and dyspepsia secondary to medication use, and severe daytime somnolence, as per progress report dated 10/13/15. The request is for MRI CERVICAL SPINE WITHOUT CONTRAST. The RFA for this case is dated 10/22/15, and the patient's date of injury is 07/27/11. Diagnoses, as per progress report dated 10/13/15, included post-traumatic head syndrome with significant headaches status post ocular surgery with history of hardware placement and subsequent hardware removal, cervical disc osteophyte at C3-4 and C6-7 with resulting cervical radiculitis versus radiculopathy and intermittent paraesthesias of right upper extremity, cervicogenic headaches, and cervical myofascitis. Medications include Fioricet, Percocet, Gabapentin and Prilosec. Diagnoses, as per progress report dated 10/08/15, included post-traumatic cervical spondylosis, cervical stenosis, right-sided C7 radiculopathy, and cervicalgia. As per neurology report dated 10/27/15, the patient has been diagnosed with sleep apnea. The reports do not document the patient's work status. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8, Neck and Upper Back, pages 177-178 under "Special Studies and Diagnostic and Treatment Considerations" states: Neck and upper back complaints, under special studies and diagnostic and treatment considerations: Physiologic evidence of tissue insult or neurologic dysfunction. It defines physiologic evidence as a form of "definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans." ACOEM further states that "unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient imaging to warrant imaging studies if symptoms persist." ODG Guidelines, Neck and Upper Back (acute and chronic) Chapter, under Magnetic Resonance Imaging states: Not recommended except for indications listed below. Indications for imaging MRI: Chronic neck pain (equals after 3 months of conservative treatment), radiographs are normal, neurologic signs or symptoms present. Neck pain with radiculopathy of severe or progressive neurologic deficit. In this case, the patient has had at least two cervical MRIs in the past. A prior MRI of the cervical spine, dated 04/29/14 and reviewed in progress report dated 10/13/15, revealed moderate central stenosis at C5-6 with disc protrusion, osteophyte formation, and congenital narrowing; diffuse congenital narrowing of cervical spinal canal; and multilevel neural foraminal narrowing, greatest at bilateral C4-5 and right C5-6. Another MRI of the cervical spine, dated 12/19/13 and reviewed in progress report dated 10/08/15, revealed osteophyte complexes at C3-4 and C6-7 with mild stenosis at C3-4 and moderate to severe stenosis at C6-7. Physical examination of the cervical spine, as per progress report dated 10/13/15, revealed constant tightness in the paraspinal musculature that increases with deep palpation, weakness of biceps and wrist flexors on the right, and significantly decreased biceps and triceps reflexes on the right. As per progress report dated 10/08/15, the patient has

numbness along the C7 distribution to light touch. In Pain management progress report dated 10/13/15, the treater states that the patient is a candidate for surgery, most likely an anterior cervical discectomy and fusion. The treater also mentions that "there is a concern high in the cervical spine with suspicion of type I odontoid fracture. I would like to obtain a better view of bony anatomy as well." In orthopedic progress report dated 10/08/15, the treater states that the patient needs a repeat MRI "to have an updated study evaluating the degree and nature of his stenosis." The patient is showing "progressive worsening of myelopathic symptoms," and the treater is concerned that this is progressing into "cervical myelopathy and this might be irreversible." ODG allows for repeat MRIs if there has a progression of neurologic deficit. Given the suspicion of worsening myelopathy, an MRI appears reasonable and IS medically necessary.