Case Number:	CM15-0231959		
Date Assigned:	12/07/2015	**Date of Injury:**	02/01/1999
Decision Date:	01/19/2016	**UR Denial Date:**	11/12/2015
Priority:	Standard	**Application Received:**	11/25/2015

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: 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:

This 63-year-old male sustained an industrial injury on 12-1-99. Documentation indicated that the injured worker was receiving treatment for chronic neck and back pain. Previous treatment included cervical fusion at C3-4 and C4-5, foraminotomy at C4-C6, lumbar fusion at L5-S1, epidural steroid injections, physical therapy, injections, pain management and medications. In an initial evaluation dated 6-11-15, the injured worker complained of "moderate to horrible" neck and low back pain with radiation to bilateral upper and lower extremities. The injured worker stated that the pain was severe and that he was forced to spend most of his time lying in bed. Any movement increased the pain. The injured worker stated that it was difficult to drive and that he needed to use crutches for ambulation. The physician noted that the injured worker was unable to use either arm without causing increased pain to his neck. In an initial neurosurgical evaluation dated 10-22-15, the injured worker complained of constant neck and low back pain radiating down both arms and legs associated with numbness, tingling and daily headaches as well as constant upper and mid back pain. Physical exam was remarkable for cervical spine with tenderness to palpation over the paraspinous region with spasms, range of motion: flexion 30 degrees, extension 35 degrees, bilateral lateral bend 15 degrees, bilateral rotation 40 degrees, negative cervical compression, distraction and foraminal compression tests, decreased sensation in the left C5-8 distributions and trace biceps and triceps reflexes. The physician recommended magnetic resonance imaging cervical spine and lumbar spine and computed tomography cervical spine and lumbar spine to determine a more specific diagnosis and help formulate a treatment plan. On 11-12-15, Utilization Review noncertified a request for magnetic resonance imaging 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: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back - MRIs.

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 (e.g., 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. Per progress report dated 10/22/15, it was noted that physical exam revealed deceased sensation in the left C5-C8 distribution and trace biceps and triceps reflexes. I respectfully disagree with the UR physician's assertion that there were no findings of radiculopathy. The request is medically necessary.