

<b>Case Number:</b>	CM14-0027200		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	01/20/2010
<b>Decision Date:</b>	08/18/2014	<b>UR Denial Date:</b>	02/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/03/2014

### 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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 claimant was injured on 01/20/10. An MRI of the cervical spine is under review. He reportedly was injured while patching a leak on a roof and climbing a 20 foot ladder. He was carrying a 10 pound bucket of sealer and he fell 18 feet landing on his back. He was diagnosed by an x-ray with cervical narrowing and spurring and limited range of motion but no fracture. His current assessments include cervical sprain rule out herniated disc. On 01/31/14, he was evaluated and had neck and head pain. X-rays revealed cervical spine narrowing and spurring with limited motion and no fractures. He saw the treating physician on 01/29/14 for a pain management consultation and reported chronic back pain. He was taking medications including tramadol, omeprazole, and cyclobenzaprine. He had not returned to work. The cervical spine was not examined. On 01/31/14, he saw the treating physician for an initial orthopedic consultation. He complained of frequent headaches and pain in his neck that increases with flexion and extension. He also had pain in his low back. He could not remember the names of his medications. The physical examination revealed mildly decreased range of motion of the neck. There was decreased lordosis with tightness, spasm and guarding, and positive Spurling's and foraminal compression tests. He did have some mild weakness. He was diagnosed with a cervical sprain, rule out herniated disc. His history of treatment from the date of injury until these visits is unclear. Electrodiagnostic studies were ordered along with an MRI of the cervical spine. TENS unit was also recommended. Physical therapy (PT) was ordered for 6 weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI CERVICAL SPINE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**Decision rationale:** The history and documentation do not objectively support the request for an MRI of the cervical spine at this time. The MTUS state criteria for ordering imaging studies are, emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). In this case, there is no evidence of a trial and failure of a reasonable course of conservative care for the cervical spine, including an exercise program, local modalities, and the judicious use of medications. PT was ordered but it is not clear whether he attended it and completed it or whether he has currently involved in an ongoing exercise program. His course of treatment for his cervical spine from the date of injury until early 2014 is unknown. There are no new or progressive focal neurologic deficits for which this type of imaging study appears to be indicated. There is no evidence that urgent or emergent surgery is under consideration. The medical necessity of this request has not been clearly demonstrated.