

<b>Case Number:</b>	CM14-0096075		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	11/17/2009
<b>Decision Date:</b>	09/22/2014	<b>UR Denial Date:</b>	05/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/24/2014

### 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 Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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 injured worker is a 46-year-old female who reported injuries from continuous and repetitive trauma on 11/17/2009. On 04/19/2014, her diagnoses included bilateral carpal tunnel syndrome, rule out bilateral ulnar nerve entrapment neuropathy and cervical and thoracic spine, rule out cervical radiculopathy. A cervical MRI done on 07/20/2011, revealed a 1 mm to 2 mm slightly asymmetrical left-sided disc bulge at C4-5. At C2-3 and C3-4, there was no significant disc desiccation or loss of disc height. The spinal canal and neural foramen remained adequate. At C5-6, there was some disc desiccation but no significant loss of disc height. There was no significant disc bulge or herniation. There was no significant facet neuropathy and the spinal canal and neural foramina remained adequate. The results were the same at C6-7 and C7-T1. A repeat cervical MRI done on 01/15/2013 revealed C2-3, C3-4, and C4-5 were unremarkable. At C5-6, there was a 2 mm posterior disc protrusion with encroachment on the subarachnoid space. There was no compromise of the cord; however, there was encroachment on the left foramen with compromise on the exiting left nerve root. Levels C6-7 and C7-T1 were unremarkable. Her complaints included continuous pain in her neck that radiated into her upper back. Her pain became worse with flexion and extension, lifting and carrying heavy items. Her pain was decreased with rest and medications. She rated her pain at 6/10. Upon examination, there were muscle spasms noted in the paraspinal musculature. Her cervical ranges of motion measured in degrees were flexion 28/50, extension 25/60, right lateral bend 24/45, left lateral bend 30/45, right rotation 73/80, and left rotation 71/80. The rationale for the requested MRI was to rule out underlying pathology in view of failure with conservative measures and persistent pain. The MRI was to help determine the pathology pertaining to this worker's residual complaints and physical findings. There was no request for authorization included in her chart.

## 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 ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** The California MTUS/ACOEM Guidelines recommend that relying solely on imaging studies to evaluate the sources of pain and related symptoms carries a significant risk of diagnostic confusion including false positive test results, because of the possibility of identifying a finding that was present before the symptoms began and therefore has no temporal association with the symptoms. False positive results have been found in up to 50% of those over age 40. Although the documentation did note that there was a failure of conservative measures, the actual therapies or medications included in the previous conservative treatment were not identified nor were the results regarding increase in functional abilities or decrease in pain. There were 2 previous MRIs done a year and a half apart and there is no rationale for a third MRI. Cervical spine x-rays were unremarkable. The clinical information submitted failed to meet the evidence based guidelines for an MRI; therefore, this request for MRI of the cervical spine is not medically necessary.