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| <b>Case Number:</b>   | CM15-0126409 |                              |            |
| <b>Date Assigned:</b> | 07/13/2015   | <b>Date of Injury:</b>       | 11/04/1997 |
| <b>Decision Date:</b> | 08/13/2015   | <b>UR Denial Date:</b>       | 06/24/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 06/30/2015 |

### 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 (IW) is a 59-year-old female who sustained an industrial injury on 11/04/1997. Diagnoses include degenerative disc disease and facet arthropathy of the cervical spine; multilevel herniated nucleus pulposus of the cervical spine with moderate stenosis; cervical radiculopathy; bilateral carpal tunnel syndrome; double crush syndrome and neural foraminal narrowing at C4-C5 on the left. Treatment to date has included medications, physical therapy, acupuncture, epidural steroid injections and activity modification. MRI of the cervical spine dated 2/20/13 showed degenerative disc disease and facet arthropathy with chronic superior and inferior end plate compression of the T2 vertebral body; canal stenosis at C4-C5 and C5-C6; and neural foraminal narrowing at C4-C5 on the left. According to the progress notes dated 5/18/15, the IW reported aching upper back pain rated 7/10 with pain, numbness, weakness or tingling radiating into the bilateral upper extremities, worse on the left. She stated the pain also radiated to the neck and head, causing headaches. She complained of bilateral shoulder pain, rated 6/10, with limited range of motion in the left arm and numbness and aching pain in the bilateral wrists. She indicated the numbness occurs mostly at night. There were also low back complaints. On examination, the cervical spine was tender in the midline, in the right paraspinal muscles and the trapezius. Range of motion of the cervical and lumbar spine was decreased in all planes. Right upper extremity sensation was decreased in the right C7 and C8 distribution. The motor exam was 4+/5 for the bilateral extensors and for the right deltoid and biceps. Spurling's test was positive on the right, causing pain to the shoulder. A request was made for repeat MRI of the cervical spine (neck), as an out-patient due to persistent pain and out-of-date exam studies.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**One repeat MRI of the cervical spine (neck): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment for Workers' Compensation (ODG-TWC) ODG Treatment Integrated Treatment/Disability Duration Guidelines Neck and Upper Back (Acute & Chronic) (updated 05/12/14).

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

**Decision rationale:** ACOEM guidelines support ordering of imaging studies for emergence of red flags, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electro diagnostic 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. MRI of the cervical spine was previously completed 2/20/13, which revealed stenosis from C4-C6. Neuroforaminal narrowing was noted at C4-C5 profoundly on the left. The ODG supports use of repeat MRIs for the cervical spine when there is a substantial change in clinical presentation that can be indicative of pathology. The documentation submitted for review does not note any change in neurologic evaluation nor is there rationale justifying repeat MRI other than the age of the MRI. The request is not medically necessary.