

<b>Case Number:</b>	CM13-0002793		
<b>Date Assigned:</b>	12/18/2013	<b>Date of Injury:</b>	07/31/2012
<b>Decision Date:</b>	02/17/2014	<b>UR Denial Date:</b>	07/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/24/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, and is licensed to practice in Texas. 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 physician 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 patient is a 55-year-old female who reported an injury on 07/31/2012. The mechanism of injury was a hose railing weighing about 40 pounds falling upon the patient's head, causing her to collapse to the floor face first. Review of the medical records revealed the patient complained of constant aching, sharp, stabbing, and shooting head and neck pain. The patient rated her pain at best 10/10. The pain increased with walking, standing, kneeling, squatting, stairs, sitting, bending, laying, carrying, pulling, pushing, writing, typing, and driving. The patient complained of numbness, tingling, weakness, anxiety, and insomnia. According to the clinical note dated 11/26/2013, the patient has received some physical therapy. Examination of the cervical spine revealed tenderness to palpation in the cervical and upper paraspinal muscle areas. The trapezius muscle group is tender to palpation as well. There is diffuse spasm palpated in the trapezius bilaterally. Active range of motion in all planes is greater than 5 degrees secondary to pain. Muscle strength was 5/5 bilaterally in all fields. Sensation was normal and equal in the bilateral upper extremities. There is mention of x-ray plain film radiographs of the cervical spine that revealed no fractures or bony abnormalities. There was noted to be significantly limited range of motion to her neck. The patient failed to flex the neck much more than 20 degrees in any direction. There was a noted significantly diminished range of motion. However, there is no evidence of impingement syndrome of the rotator cuff of either shoulder through the supraspinatus strength test for lateral impingement or the Neer's and Hawkins tests for anterior impingement. There was normal muscle strength in the upper extremities. Sensation is normal in all areas of both hands and upper extremities. EMG/nerve conduction study of the bilateral upper extremities dated 08/30/2013 a normal study of the bilateral upper extremities.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI Spinal Canal and contents and cervical with contrast materials:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180. Decision based on Non-MTUS Citation Official Disability Guidelines (Neck and Upper Back Chapter.)

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

**Decision rationale:** The patient received an MRI on 09/28/2012 after the reported incident and injury. That MRI of the cervical spine found no cervical spine fracture or edema and it also revealed multilevel mild degenerative cervical spondylosis without significant central stenosis or evidence of nerve root impingement. There are no recent changes in the objective findings documented for the patient. Per the ACOEM Guidelines, there is no physiological evidence that is found in the medical records definitive of neurological findings on physical examination or electrodiagnostic studies. The EMG/NCV that was performed also gave the results of normal findings. Therefore, there is no new information provided in the medical records to suggest that an additional MRI is warranted at this time. Therefore, the request for MRI spinal canal and contents cervical with contrast materials is not medically necessary and appropriate.