

Case Number:	CM13-0023125		
Date Assigned:	11/15/2013	Date of Injury:	11/01/2007
Decision Date:	01/07/2014	UR Denial Date:	09/06/2013
Priority:	Standard	Application Received:	09/11/2013

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 Family Practice 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.

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 56-year-old female who sustained an occupational injury reported on 11/01/2007 which was secondary to cumulative trauma of the neck and upper extremities. The patient's compensable injuries involved both her upper and lower arms, bilateral shoulders, cervical spine with inclusion of a mental claim as well. The patient's treatment history has included numerous oral medications with left radial tunnel and lateral epicondyle release on 10/09/2008, left ulnar anterior subcutaneous transposition with release procedure medially in 12/2009, cervical epidural steroid injections in 01/2012, repeat cervical steroid injections on 09/04/2012 and again in 01/2013. The patient has also received physical therapy with cortisone injections for cervical spine and shoulders and trigger point injections and Botox injections for chronic tension migraine headaches. On 08/20/2013, the patient was seen and reported that following the previous isolated trigger point injections, pain was decreased by 50% in cervical flexion and range of motion had doubled; however, when the effects wore off the severity of pain increased. Objective documentation collected on that day revealed ongoing complaints of tenderness to palpation with range of motion limitations secondary to pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of cervical spine: Upheld

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

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

Decision rationale: Magnetic Resonance Imaging (MRI) is the imaging study of choice for most abnormalities of the cervical spine and is useful in suspected nerve root compression, in myelopathy to evaluate the spinal cord and/or masses, infections such as epidural abscesses or disc space infection, bone marrow involvement by metastatic disease, and/or suspected disc herniation or cord contusion following severe neck injury. In addition, MRI should be performed immediately if there is suspicion of a red flag like the possibility of infection or metastatic disease with cord compression. While the documentation provided for review clearly indicates the patient has had ongoing chronic issues with cervical spine pain and radiculopathy, the records indicate that a cervical MRI was completed on 04/15/2012 which showed chronic appearing degenerative changes to C4-5 and C5-6 with mild central stenosis of both levels and lateral stenosis at the left C4-5. However, guidelines indicate that repeat MRI should be reserved for emergence of a red flag, failure to progress in a strengthening program, clarification of anatomy prior to invasive procedure or progressive neurological symptoms. While the patient does display pain and radiculopathy of the cervical spine, these symptoms when compared to previous visits show no progress or change in characteristic. In addition, there is no change in the patient's range of motion measurements, deep tendon reflexes or neurological evaluation either. Given the lack of documentation to indicate the existence of any red flags as well as the lack of evidence to indicate the patient has had any significant changes in her cervical spine condition the rationale for this request for MRI of the cervical spine is unclear. Therefore, this request cannot be supported and is therefore non-certified.