

Case Number:	CM13-0028007		
Date Assigned:	12/11/2013	Date of Injury:	02/24/2010
Decision Date:	02/07/2014	UR Denial Date:	09/13/2013
Priority:	Standard	Application Received:	09/23/2013

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 Orthopedic Surgery 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 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 claimant is a 59-year-old gentleman injured in a work related accident 02/24/10. Initial complaints indicate a fork lift injury resulting in left shoulder, elbow and low back complaints. Recent clinical assessments indicate a 10/24/13 left shoulder MR arthrogram was performed that showed full thickness tearing to the distal supraspinatus as well as tendinosis changes. A prior report of 09/09/13 with provider [REDACTED] indicated ongoing complaints of neck pain as well as continued pain about the shoulder. Physical examination findings that date showed a neurologic examination with diminished left C6 through 8 dermatomal sensation equal and symmetrical reflexes and 5/5 motor tone. She diagnosed the claimant with cervical degenerative disc disease and cervicalgia. She indicates that the claimant is status post a prior anterior cervical discectomy and fusion from two years prior, but based on current examination, an MRI scan was ordered to rule out disc breakdown or stenosis. She sites recent radiographs that demonstrate a solid fusion and osteophyte formation at the C4 through 6 level.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient MRI of the cervical spine with and without contrast: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 165, 17-178.

Decision rationale: Based on California ACOEM Guidelines, an MRI scan of the cervical spine would appear medically necessary. The claimant is with a prior shoulder surgical process history to include a one level C6-7 fusion. At present, there is noted to be solid fusion on imaging, but continued neurologic findings in the form of sensory change. There is no indication of postoperative MRI scans performed. The role of the acute MRI scan to rule out a neurologic process would appear to be medically necessary. Guideline criteria indicate the role of this based on failure to progress with strengthening program with physiologic evidence of tissue insult and neurologic dysfunction on examination. Unequivocal findings that identify specific nerve compromise on examination are sufficient evidence to warrant imaging if symptoms persist.