

Case Number:	CM13-0028354		
Date Assigned:	11/27/2013	Date of Injury:	11/11/2011
Decision Date:	01/13/2014	UR Denial Date:	08/22/2013
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 Physical Medicine and Rehabilitation 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 underlying date of injury in this case is 11/11/2011. The primary diagnosis is cervical spondylosis. A prior physician review notes that this patient was initially injured when struck in the head by a cart which fell from a shelf. The patient subsequently did not return to work after the date of injury. The patient has reported ongoing neck pain and difficulty sleeping with limited cervical range of motion on physical exam. The prior reviewer concluded that treatment guidelines to support the necessity of MRI imaging were not met. A request for an independent medical review in this case from the patient's attorney notes the patient's physician previously requested authorization for a cervical medial branch block and notes that the patient continues with headache, memory, balance, and cognitive impairments. That letter indicates that the patient has failed conservative treatment for over 2 years since the date of injury, and therefore a request for the MRI under review. A treating physician's note of 09/27/2013 notes that cervical plain films were unremarkable and the patient has continued neck pain and headaches and again requests an MRI of the cervical spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Magnetic Resonance Imaging (MRI) of spinal canal and contents, cervical; without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178,182.

Decision rationale: The ACOEM Guidelines, Chapter 8 Neck, page 178, states, "Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurological exam is less clear, however, further physiological evidence of nerve dysfunction can be obtained before ordering an imaging study." The medical records do not contain such specific neurological findings to suggest a particular differential diagnosis. Noted as well that the ACOEM Guidelines, Chapter 8 Neck, page 182, recommends, "MRI to validate diagnosis of nerve root compromise, based on clear history and physical exam findings, in preparation for invasive procedure." This patient has both axial and possibly radicular symptoms. This patient does not clearly have neurological findings as per this guideline. Overall the medical records and guidelines do not support this request. This request is not medically necessary.