

Case Number:	CM13-0033892		
Date Assigned:	12/06/2013	Date of Injury:	05/24/2011
Decision Date:	02/19/2014	UR Denial Date:	09/25/2013
Priority:	Standard	Application Received:	10/11/2013

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 Physical Medicine and Rehabilitation and is licensed to practice in Oklahoma and 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 46-year-old male who reported an injury on 05/24/2011. The mechanism of injury was reported that the patient fell down some metal stairs from the second floor to the first floor. The patient was diagnosed with status post right knee arthroscopy in 2012, status post left knee arthroscopy in 2011, status post right shoulder rotator cuff repair 2011, lumbar spine strain, cervical spine strain, migraine headaches with memory loss, gastrointestinal complaints, and complaints of depression, anxiety, and sleep difficulty. The patient stated he had a chronic constant heavy achy feeling in his neck. The patient reported that the pain radiated down to the right shoulder. The patient also stated that he had stiffness, numbness, and tingling. Physical examination of the cervical spine revealed no loss of the normal cervical lordosis nor were there any other abnormal curvatures. There was a muscle guarding/spasm present. There was no tenderness to palpation of the paraspinal musculature and no palpable abnormalities. An MRI done in 2012 indicated that the patient had C6-7 disc herniation.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Neck and Upper Back.

Decision rationale: The Official Disability Guidelines state that repeat MRIs are not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). The clinical documentation submitted for review showed an MRI done in 2012 indicating that the patient had C6-7 disc herniation. However, the clinical documentation does not note any recent change in symptoms for the patient. Given the lack of documentation to support guideline criteria, the request for an MRI of the cervical spine is non-certified.