

Case Number:	CM13-0042932		
Date Assigned:	12/27/2013	Date of Injury:	07/24/2008
Decision Date:	10/20/2014	UR Denial Date:	10/16/2013
Priority:	Standard	Application Received:	10/21/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Orthopaedic 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 expert 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:

This 46-year-old female security guard sustained an industrial injury on 7/24/08. Injury occurred when she was struck by a car as a pedestrian. She injured her elbows, shoulders and neck. Past surgical history was positive for left ulnar transposition in 2011. Past medical history was positive for a fracture at C2/3 in 1996 with halo application and full recovery. The patient underwent an anterior cervical discectomy and fusion at C3/4 with instrumentation, structural allograft and bone morphogenetic proteins on 5/29/13. The 5/31/13 progress report indicated the patient complained of severe neck pain and felt a popping sensation in her neck after surgery. The 6/1/13 cervical CT scan impression documented the patient was status post anterior plate and screw fixation at C3/4 with intervertebral cage graft. A 2 mm posterior disc bulge was present that effaced the ventral thecal sac and abutted the anterior margin of the cervical cord causing mild to moderate canal stenosis. Hardware was intact with no backing out of screws. Uncovertebral joint arthropathy caused mild right neuroforaminal narrowing. There was pre-vertebral fluid measuring 0.7 mm AP and 10 cm sagittal from the level of C1 to C7. Post-operative edema was present in the soft tissues. There was a small 1 mm posterior disc bulge causing mild central canal narrowing at C5/6. The patient reported on-going neck and left upper extremity pain post-operatively. The 9/10/13 treating physician report indicated the patient was having a lot of jerking movements and felt popping in her neck. Physical exam documented some hypersensitivity of the reflexes. Whole body jerks were seen. There was negative clonus in both lower extremities. Hoffman sign was equivocal. The treating physician opined the need to rule-out major spinal cord compression. The treatment plan requested authorization for cervical MRI with and without contrast, MRI of the brain and bilateral upper extremity EMG/NCV. The 10/16/13 utilization review denied the request for cervical MRI as there was no significant

clinical deterioration to support the medical necessity of a repeat MRI. Associated requests for MRI of the brain and bilateral upper extremity EMG/NCV were certified.

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 CERVICAL SPINE WITH AND WITHOUT CONTRAST: Upheld

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): 177-178, 182. Decision based on Non-MTUS Citation Official Disability Guidelines MRI.

Decision rationale: The California MTUS guidelines provide criteria for ordering cervical spine MRIs that includes emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure in a strengthening program intended to avoid surgery, or clarification of anatomy prior to an invasive procedure. The Official Disability Guidelines state that repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). Guideline criteria have not been met. There is no significant change in cervical symptoms and/or findings suggestive of significant pathology to support the medical necessity of repeat MRI. An MRI of the brain and bilateral upper extremity EMG/NCV were approved to evaluate the current complaints of whole body jerking. Therefore, this request is not medically necessary