

Case Number:	CM13-0048750		
Date Assigned:	12/27/2013	Date of Injury:	05/16/2008
Decision Date:	04/25/2014	UR Denial Date:	10/24/2013
Priority:	Standard	Application Received:	11/06/2013

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 Physical Medicine & Rehabilitation and is licensed to practice in Pediatric Rehabilitation Medicine. 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:

The patient is a 53-year-old female who reported an injury on 05/16/2008. The mechanism of injury was a fall off of a horse and sustained multiple fractures of her spine and an injury to her elbow. The patient has had an MRI of the thoracic spine on 05/03/2013 as well as a cervical spine x-ray on 03/15/2013 which revealed discogenic disease at C5-6 with suggestion of associated bilateral foraminal encroachment; associated anterior and posterior spurring with the associated foraminal encroachment; sclerosis and narrowing of the apophyseal joints; reversal of the normal lordotic curvature suggesting muscle spasm. Thoracic spine x-ray dated 03/15/2013 revealed mild scoliosis of the thoracic spine convex to the right; no destructive processes are identified; and there is anterior spurring. The patient has been treated with acupuncture and physical therapy. Surgical history noted on clinical note is tubal ligation and appendectomy with no date for either. Per the clinical note dated 07/03/2013, the patient complained of pain behind her left ear since the 07/25/2008 injury. The clinical note states the patient has had an MRI of the cervical area only; however, this report was not provided for review. The patient complained of pain behind her left ear and this area was swollen and was causing headaches. The patient stated that when she turns her head to the right she gets dizzy, lightheaded, and feels she may lose consciousness or have an altered level of consciousness. On physical exam, the patient is noted to have full range of motion to the neck; however, on right lateral rotation, the patient complained of dizziness. The test was repeated again and when looking to the left, the patient had rotary nystagmus with fast component to the left that sustained itself for 3 to 5 seconds. The patient did complain of pain with extension and right lateral rotation on the left hand side and there was spasm noted mildly in the left paraspinous cervical area. Neurological examination revealed muscle strength of 5/5 and sensation was intact with 2+ symmetrical deep tendon

reflexes. An MRI of the cervical spine was requested on 10/07/2013 and did not provide a rationale. An examination of the cervical spine was not performed on this date.

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 W/O CONTRAST: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Neck and Upper Back (Acute and Chronic)

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 Chapter, MRI

Decision rationale: Official Disability Guidelines state 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). The documentation provided indicated the patient had a prior cervical MRI; however, the MRI report was not submitted for review. In the clinical notes provided, the patient complained of headaches, low back pain, and no change in cervical spine pain. The most recent thorough examination of the patient failed to support neurological deficits as it relates to the cervical spine to support the necessity of the MRI. The patient was noted to have intact sensation, deep tendon reflexes and muscle strength. Given the lack of documented objective change in symptoms or new or progressive neurological deficits, the request does not meet guideline criteria. Therefore, the request for the cervical MRI without contrast is non-certified.