

Case Number:	CM13-0050356		
Date Assigned:	12/27/2013	Date of Injury:	01/19/2009
Decision Date:	10/24/2014	UR Denial Date:	10/30/2013
Priority:	Standard	Application Received:	11/13/2013

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 Licensed in Psychology 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 61-year old man reported injuries to his neck and shoulder after a fall on 1/19/2009. Most of the following history was obtained from the UR reports dated 8/19/14 and 10/30/14, since there is little clinical information in the available records. The patient has had multiple surgeries including a 2009 R shoulder decompression and a 2012 C4-6 fusion with instrumentation. The cervical surgery was complicated by chronic cervical and arm pain with symptoms of C6 radiculopathy felt to be caused by hardware and scar tissue. The hardware was removed and scar tissue excised in 4/2013. The pain and radicular symptoms persisted, and the patient's pain management specialist requested a cervical epidural steroid injection, which was authorized. There is no documentation in the records that the ESI was performed. There is a 10/10/13 progress from a pain specialist in the record which requests a cervical ESI, and makes no reference to one having been performed previously. There are two progress notes in the records from the primary treating physician's office, both signed by a PA. The first, on 9/11/13, documents neck pain, a healed scar, neck tenderness and pain with terminal motion. There is no documentation of any radicular symptoms, and no upper extremity sensory, motor or neurological exam was performed. The second report, of an exam performed 9/25/14, was almost identical, and again documented no complaints or findings suggestive of radiculopathy. The PA did injections of Toradal and vitamin B12 on both dates, and a urine drug screen was performed on both dates. Diagnoses included S/P C4-6 anterior cervical microdiscectomy with implantation of hardware; S/P R shoulder surgery with recurrent full thickness rotator cuff tear and impingement syndrome; L shoulder internal derangement with MRI evidence of full thickness supraspinatus tendon tear; and S/P L4-5 posterior lumbar interbody fusion. Requests were made at both visits for additional PT, for a cervical MRI and for a lumbar MRI. The rationale for the

cervical MRI states "This is per ACOEM pg. 176, as the patient has had cervical spine limitations due to consistent symptoms greater than 4-6-weeks."

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical MRI w/o Contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178, 182.

Decision rationale: Per the ACOEM reference cited above, criteria for ordering imaging studies include emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, or clarification of anatomy prior to an invasive procedure. Unequivocal exam findings that identify specific nerve root compromise are sufficient evidence to warrant imaging studies if symptoms persist. MRI or CT is recommended to validate nerve root compromise based on clear clinical findings in preparation for an invasive procedure. The clinical findings in this case do not support the performance of an MRI of the cervical spine. This patient has already had multiple invasive procedures, and epidural steroid injections appear to be pending. Although reports are not included in the available records, it is clear that the patient has had one or more MRIs in the past. The only clinical records available document the patient's complaints and exam as unchanged, and are notable for a complete lack of documentation of any symptoms or findings of nerve root compromise. Based on the evidence-based citations above and the clinical findings in this case, a cervical MRI without contrast is not medically necessary because the patient has no new concerning symptoms, because there is no documentation of physical findings of nerve root compromise, and because no additional invasive procedures are planned beyond the ESI already authorized.