

Case Number:	CM13-0065330		
Date Assigned:	01/03/2014	Date of Injury:	11/03/2010
Decision Date:	04/15/2014	UR Denial Date:	12/06/2013
Priority:	Standard	Application Received:	12/13/2013

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 Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pediatric Rehabilitation Medicine and is licensed to practice in 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 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 54-year-old female with a reported date of injury of 01/03/2010. The patient presented with neck pain, low back pain, mid back pain, ongoing tingling and numbness down both of the arms in to her hands on the left greater than the right, decreased cervical spine range of motion, decreased sensation at the right C6 dermatome, 4+/5 strength in the left deltoids, biceps, and internal and external rotator, 5-/5 strength in the right upper extremity. The patient did not have any bowel or bladder incontinence. The patient had diagnoses including status post anterior cervical decompression and fusion at C4-5, C5-6, and C6-7 on 04/25/2013, cervical radiculopathy, herniated nucleus pulposus of the lumbar spinal stenosis, and lumbar radiculopathy. The physician's treatment plan included a request for an MRI of the cervical spine without contrast between 12/04/2013 and 01/18/2014.

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 WITHOUT CONTRAST: Overturned

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): 181-183.

Decision rationale: The California MTUS guidelines do not address cervical spine MRI. ACOEM recommends the use of MRI or CT to evaluate red-flag diagnoses (fracture, or neurologic deficit associated with acute trauma, tumor, or infection) and the use of MRI or CT to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure if the patient has had no improvement after 1 month of conservative care. Per the provided documentation the patient underwent anterior cervical decompression and fusion at C4-5, C5-6, and C6-7 on 04/25/2013. The primary treating physician's progress report from 05/08/2013 indicated the patient reported a significant decrease in pain and numbness in her arms as well as in her neck after surgery. The patient was only experiencing some tingling sensation in her hands and stated that almost all of her arm symptoms were resolved after the surgery. The primary treating physician's progress report dated 08/31/2013 noted the patient reported ongoing tingling and numbness down both of her arms into her hands. The primary treating physician's progress report dated 09/28/2013 noted the patient reported increasing tingling in pins and needles on the hands as well as increased pain in her hands since the prior visit. The patient was having more upper extremity tingling and numbness but was not dropping objects. The patient had decreased sensation to the right C6 and C7 dermatomes. The provider indicated the patient was experiencing increased tingling and numbness in the hands as well as she was feeling weaker in her arms, and therefore, an electromyogram/nerve conduction study of the bilateral upper extremities was recommended. An electrodiagnostic showed no evidence of focal nerve entrapment, cervical radiculopathy, or generalized peripheral neuropathy affecting the upper extremities. An MRI of the cervical spine was performed on 11/06/2012 which revealed degenerative disc disease straightening of the normal cervical lordosis, canal stenosis including C3-4 was mild, C4-5 was mild to moderate, C5-6 was mild to moderate, and C6-7 had moderate canal stenosis without neural foraminal narrowing at any level. Per the provided documentation, the patient had increased subjective complaints of numbness and tingling in the upper extremities from May to September. It was noted the patient had decreased sensation in the C6 dermatome in May which changed to decreased sensation in the C6 and C7 dermatomes in September. Per the provided documentation, it appeared the patient had progression of symptoms as well as increased complaints of numbness and tingling and decreased sensation upon physical examination. Therefore, the request for an MRI of the cervical spine without contrast would be medically necessary and appropriate.