

Case Number:	CM13-0070368		
Date Assigned:	01/03/2014	Date of Injury:	06/11/2013
Decision Date:	06/05/2014	UR Denial Date:	11/13/2013
Priority:	Standard	Application Received:	12/20/2013

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 Pain Management 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:

The patient is a 57 year-old female who was injured on 06/11/2013. She sustained an injury when she tripped over a metal rod that was on the floor. She did not completely fall but rather jerked causing a sharp pain in her lower back radiating through her neck and shoulders. She was sent to [REDACTED] in [REDACTED], where she underwent x-rays of her neck, shoulders and lower back. Prior treatment history has included 3-4 sessions of therapy, hot towels and electro stimulation. Diagnostic studies reviewed include x-ray of the cervical spine performed on 06/11/2013 revealed minimal two-level cervical spondylosis and no other abnormality. X-ray of sacroiliac joints revealed a negative study of the sacroiliac joints; x-ray of the lumbar spine revealed minimal degenerative change at T12-L1 and postoperative change in the right upper quadrant with no other abnormality. A PR2 dated 07/15/2013 documented that the patient had a constant chronic achy pain in her neck, which radiated to both shoulders, greater on the left side. She denied any numbness or tingling sensations associated with the neck pain. Cervical spine examination revealed no loss of the normal cervical lordosis, or any other abnormal curvatures. There was no visible deformity or step-off. Muscle guarding was present. The patient did complain of increasing pain towards terminal range of motion. There was tenderness to palpation of the paraspinal musculature. There were no palpable abnormalities; Spurling and Adson's test were negative bilaterally. Neurological examination was normal (sensory, motor and reflexes were intact with no gross focal deficits). X-ray of the cervical spine done during the office visit revealed normal bone quality and evidence of mild degenerative disc disease at C4-C5. Chronic neck pain, rule out herniated disc, right and left shoulder painful motion secondary to chronic neck pain, chronic low back pain, rule out herniated disc, and complaints of anxiety, depression and sleep difficulty were the listed diagnoses. A recommendation was made for additional physical therapy at a rate of two times per week for six

weeks based on the MTUS, AAOS, AOA, and AOSS guidelines. A PR2 dated 10/09/2013 documented that the patient had completed 4 sessions of therapy for the cervical and lumbar spine and reported that it was not helping her. She complained of lumbar spine pain 8/10. She was using a back brace. The thoracic spine pain was 8/10, and cervical spine pain was 8/10. She reported anxiety, depression, and lack of sleep. Objective findings on cervical spine examination revealed muscle guarding and increasing pain towards terminal range of motion. On palpation, there was tenderness to palpation of the paraspinal musculature. Shoulder exam revealed that patient complained of increasing neck pain towards terminal range of motion bilaterally. There was not a painful arc against resisted abduction bilaterally. There was myofascial tenderness to palpation bilaterally of the trapezius. The elbow exam was normal. The wrist and hand exam revealed decreased grip strength on the right. The applicant did complain of increasing low back pain towards terminal range of motion. The gait was not antalgic. The patient was able to walk on toes and heels; however complained of low back pain. Lumbar spine examination showed no loss of the normal lumbar lordosis or any other abnormal curvatures. There was no visible deformity, or step-off. There was muscle guarding present. The patient did complain of increasing pain towards terminal range of motion. There was paraspinal musculature tenderness to palpation. There was tenderness to palpation of the spinous processes. The patient was diagnosed with 1) Chronic neck pain, rule out herniated disc; completed 3 sessions with no improvement; 2) Right and left shoulder painful motion secondary to chronic neck pain; 3) chronic low back pain, rule out herniated disc; 4) Complaints of depression, anxiety, and sleep difficulty.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI CERVICAL SPINE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM CHAPTER ON CERVICAL & THORACIC SPINE DISORDERS, SECTION ON MAGNETIC RESONANCE IMAGING (MRI).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), NECK AND UPPER BACK (ACUTE AND CHRONIC), MAGNETIC RESONANCE IMAGING (MRI).

Decision rationale: Regarding the request for cervical MRI, guidelines support the use of imaging for emergence of a red flag, physiologic evidence of tissue insult or neurologic deficit, failure to progress in a strengthening program intended to avoid surgery, and for clarification of the anatomy prior to an invasive procedure. Guidelines also recommend MRI after 3 months of conservative treatment. Within the documentation available for review, there is no indication of any red flag diagnoses. Additionally there is no documentation of neurologic deficit on physical examination. In the absence of such documentation the requested cervical MRI is not-medically necessary.