

Case Number:	CM14-0004512		
Date Assigned:	02/05/2014	Date of Injury:	03/05/1997
Decision Date:	09/05/2014	UR Denial Date:	12/27/2013
Priority:	Standard	Application Received:	01/13/2014

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 Neurology 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 Injured Worker (IW) is a 58 year-old female who suffered an injury on 3/5/1997; the two medical reports from the primary treating physician (PTP) provided for this review, dated 5/8/2014 and 7/2/2012, do not state the mechanism or nature of the injury. These reports indicate that the IW has diagnoses of Bilateral Carpal Tunnel Syndrome, Cervicalgia, Brachial Neuritis Not Otherwise Specified, and Injury to Ulnar Nerve. The IW complains of worsening generalized neck pain with position related bilateral arm numbness and weakness exacerbated with prolonged neck flexion. Both records indicate the IW has been using non-steroidal anti-inflammatory medications and Percocet 5/325 as needed for pain symptoms. It is apparent from the 7/2/2012 record that physical therapy had been prescribed but there is no history supporting that such sessions were completed. Both records reviewed were absent to mention as to what other, if any, conservative treatment modalities have been attempted. Physical exam findings on 7/2/2013 were notable for primarily for signs consistent with ulnar impingement, while cervical findings were unremarkable, noting full range of motion in all planes described and normal deep tendon reflexes symmetrically. A request for a cervical MRI to clarify the IW's complaint of worsening symptoms was submitted on 12/16/2013 and was denied in a Utilization Review (UR) dated 12/27/2013. A clinical exam subsequent to the appeal (5/8/2014) reveals findings particular to the cervical spine differing from that of 7/2/2012 exam: there is a decrease in cervical range of motion (flexion 30-degrees, extension 20-degrees) and diminished deep tendon reflexes symmetrically (0-1+); Spurling's maneuvers produce shooting pain and numbness bilaterally in the upper extremities; and moderate tenderness is noted at the right greater occipital nerve at the Nuchal ridge, provocation at which reproduces headache symptoms (IW's symptoms of headache have not been noted elsewhere in the contents of either examination). This later medical record (5/8/2014) also references the results of a cervical MRI conducted on 4/7/2014.

The findings from that MRI, however, cannot be used to medically-necessitate the request for an MRI itself. As such, the MRI findings of 4/7/2014 are irrelevant for the purposes of this review. Medical necessity for a cervical MRI is therefore determined on the basis of the clinical findings relevant to the cervical spine reported in the 7/2/2012 and 5/8/2014 exams.

IMR ISSUES, DECISIONS AND RATIONALES

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

CERVICAL MRI: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 165-194.

Decision rationale: The MTUS incorporated ACOEM Guidelines specific to the neck and upper back indicate that special studies (e.g., MRI) are appropriate where there exists red flags (i.e., fractures, tumors, infections, cervical spinal cord compromise) indicating serious etiology for symptoms. Determination of a red flag condition is predicated upon a significant medical history (e.g., traumatic injury, cancer, immune compromise) which directly correlates to severe symptomology (see Table 8-1, p. 167). The absence of such flags rules out the necessity of special studies. In this case, a sufficient medical history as it correlates to the onset of the IW's symptoms is absent from the reports provided, listing only the date of injury as occurring nearly 17 years earlier. The physical findings on the two clinical exams, separated temporally by nearly two years themselves, are neither sufficient nor specific enough to indicate the development of a severe neurological deficit which qualifies as a red flag. For non-red-flag conditions (for example, where stenosis may be suspected), MRI or CT studies are appropriate when the unique signs and corresponding unique symptoms of such are unequivocal (See Table 8-4, p. 172). The neurological exams presented in this case are unclear and insufficient to determine unequivocally the source of nerve compromise. For example the reports indicate that the IW's symptoms worsen with neck flexion, whereas the unique signs (as stated in the table) for suspected stenosis are typically worsening with extension and improving with neck flexion. Additionally, some symptomology and exam findings (e.g., reports of numbness in upper extremities and hands with provocation testing) may also be attributable to an ulnar impingement. The ACOEM discussion of special studies and diagnostic considerations indicates that imaging tests are warranted when there is sufficient physiological evidence of definitive findings for neurological dysfunction identified by specific nerve. Where the neurological examination findings are less clear, additional evidence of neurological dysfunction should be obtained through additional physiological testing, e.g., electromyography, nerve conduction velocity studies, H-reflex testing. With sufficient physiological evidence indicating a specific nerve impairment or insult, the selection of appropriate imaging tests may be considered. In this case, the neurological findings from both physical exams are neither specific nor sufficient enough to unequivocally differentiate the source of nerve compromise. There are no records submitted which indicate additional testing to clarify specific nerve compromise has been conducted. In the absence of the

definitive physiological evidence required by the ACOEM Guidelines, the Cervical MRI is not medically necessary.