

Case Number:	CM14-0007545		
Date Assigned:	04/02/2014	Date of Injury:	09/19/2011
Decision Date:	05/26/2014	UR Denial Date:	12/10/2013
Priority:	Standard	Application Received:	12/18/2013

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 Medicine 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 48 year old male who was injured on 09/19/2011 while running with a backpack blower on hills. He experienced sudden onset of pain in the mid-back. Prior treatment history has included (list prior treatments). The patient underwent an epidural steroid injection on 10/29/2013. Diagnostic studies reviewed include x-rays of the thoracic spine dated 08/16/2013 was negative. X-rays of the lumbar spine dated 08/16/2013 revealed no acute findings. CT of the cervical spine without contrast dated 08/16/2013 revealed no acute findings. Industrial Recheck dated 11/07/2013 reported the patient was last seen for the epidural block performed fairly on 10/29/2013. Unfortunately, this seemed to have flared his symptoms, especially 2 days afterwards, which had began to ease somewhat. He had a headache, especially in the first 24 hours. He had no fevers or chills, and no increased numbness or weakness in the extremities, fortunately. His pain severity was at 9/10 and somewhat sharp. He stated he could not drive, and he last drove about a couple of months ago, just for about 1 mild maximally, as it was very difficult to turn to the left. He was trying to do his home exercises but with difficulty. He received driving services. He needed a statement that was okay for him to have a driver to bring him all the way from his home in [REDACTED]. On examination, his cervical spine had reduced range of motion without sign of erythema, fluctuance, or streaking at the sites of the cervical epidural block and left T6-7 epidural block. He was notably afebrile to touch, as well. His upper extremities were normal without observable abnormality or asymmetry of temp, color, contour, or size. Neurologic exam revealed the patient was mentally alert, attentive and oriented to reasons for being in the clinic; without signs of agitation, drowsiness, or of being in an overmedicated state. Clinical Report dated 08/16/2011 documented the patient to have complaints of severe pain. The patient complained of neck pain and sustained a mild bow to the head. The patient had severe chronic radicular back and neck pain with chronic neuropathy. On

exam, he had decreased range of motion; pain in the neck upon movement. There was no muscle spasm in the neck and was nontender. The patient had diffuse tenderness to entire back midline and lateral. There was no ecchymosis, but step off was noted. Extremities were normal on inspection. The pelvis was stable. Extremities were atraumatic with no lower extremity edema. He was oriented x3 with no motor deficit. Reflex exam revealed right biceps 1+, left biceps 1+; right patellar 1+; left patellar 1+; and right Achilles 1+. Industrial Record dated 09/30/2013 stated the patient reported having persistent neck pain and shoulder region pain. His pain was worse in the intracapsular region bilaterally, but worse on the left side. On examination, spasms were noted in the bilateral scapular region musculature, worse on the left side; Dysesthesia was noted to light touch in the left T3 to T7-T8 dermatomes; otherwise, no gross change was noted.

IMR ISSUES, DECISIONS AND RATIONALES

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

REPEAT CERVICAL MRI: Upheld

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

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

Decision rationale: The Expert Reviewer's decision rationale: As per CA MTUS guidelines, unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. In this case, this patient reports severe neck pain despite trial of physical therapy, medications, and ESI. CT of the cervical spine showed no acute findings. On physical exam, there is documentation of decreased cervical ROM; however, there is no evidence of abnormal neurologic findings including decreased reflexes, sensation, or strength in bilateral upper extremities to warrant cervical MRI. Thus, the request for MRI of the cervical spine is not medically necessary.