

Case Number:	CM14-0109228		
Date Assigned:	08/01/2014	Date of Injury:	03/10/2011
Decision Date:	10/01/2014	UR Denial Date:	06/25/2014
Priority:	Standard	Application Received:	07/14/2014

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 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 53 year old male who sustained an industrial injury on 3/10/2011, now over 3.5 years postdate of injury. MOI refers to development of DVT in the left upper extremity manifested as swelling and pain. He was diagnosed with TOS and subsequently underwent first rib resection on 4/20/2011. He complained of left shoulder pain and subsequently underwent left shoulder SAD and biceps tenodesis on 10/27/2011. He continued with left arm symptoms. He is also status post C4-C7 fusion on 2/27/2013. He has attended PT post-surgery. Cervical spine radiographs obtained on 1/14/2014 reveals C5-6 and C6-7 fusion without abnormal motion, mild spondylosis C3-4 and C4-5. According to the physical therapy report dated 6/6/2014, the patient complains of 5/10 neck pain and continued pain, numbness and tingling into the left arm. Physical examination shows limited cervical AROM, hypertonia on palpation left greater than right in the upper back and cervical musculature, intact sensation, reflexes WNL, and 4+/5 myotomes in C3 through T1. According to the 6/19/2014 progress report, the patient complains of neck and back pain rated 5 on VAS and left arm and leg pain rated 4 on VAS. He is not working. Medications are soma, Benadryl and Ambien. Physical examination reveals no pain on palpation of the cervical and trapezius musculature, 5/5 upper extremity strength except for 4/5 left wrist extension, decreased sensation along the radial forearm to the middle and long fingers, 2+ reflexes, and negative Hoffman's, clonus, Spurling's, Phalen's and elbow flexion tests bilaterally. There is no atrophy of the biceps, triceps forearms and hand intrinsics. Reviewed records include cervical x-rays 9/16/2013 and 1/14/2014. Diagnoses are: 1. C5-6, C6-7 disc herniation, CT, industrial; 2. S/P C5-6, C6-7 ACDF; 3. Lumbar strain, CT, industrial; 4. Left thoracic outlet obstruction s/p surgery with DVT, industrial; 5. Depression secondary to industrial neck and back pain. Plan includes MRIs w/o contrast of the thoracic, lumbar and cervical spines, AP/lateral thoracic x-rays.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI without contrast, Cervical: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM.

Decision rationale: The CA MTUS ACOEM guidelines state the criteria for ordering imaging studies are: Emergence of a red flag; Physiologic evidence of tissue insult or neurologic dysfunction; Failure to progress in a strengthening program intended to avoid surgery; and Clarification of the anatomy prior to an invasive procedure. The medical records do not appear to reveal consistent neurological findings that establish there is a progressive neurological deficit. There is no evidence of an emergence of a red flag, and the patient is not pending invasive procedure. In addition, a cervical MRI was performed in previously performed in 2012. The ODG states repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, and recurrent disc herniation), which has not been established in this case. The medical records do not establish there has been a significant change in symptoms and/or findings to suggest significant pathology present. The medical necessity for an updated cervical MRI has not been established. The request is not medically necessary.