

Case Number:	CM14-0120800		
Date Assigned:	08/06/2014	Date of Injury:	06/07/2014
Decision Date:	09/11/2014	UR Denial Date:	07/16/2014
Priority:	Standard	Application Received:	07/30/2014

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 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:

This is a patient with a date of injury of 6/7/14. A utilization review determination dated 7/16/14 recommends non-certification of MRI of the cervical spine. 6/26/14 EMG/NCS report identifies findings consistent with mild-moderate carpal tunnel syndrome on the left with no evidence of ulnar or radial neuropathy or cervical radiculopathy. 7/28/14 medical report identifies that the MRI was denied. Neck pain is 1-2/10 after PT. Area of radiation, numbness, and tingling down the LUE has decreased and is now down to the ulnar aspect of the distal left forearm and numbness/tingling at the left small finger. The patient has started to wear the left wrist splint and continues that his left middle finger feels like it is going to fall off. He notes a decrease in left hand strength. On exam, there is paracervical tenderness, decreased sensation left small finger, Spurling's test negative bilaterally, and deep palpation no longer reproduces radiating pain down the LUE or increased numbness /tingling at the left small finger. The provider notes that he is suspicious for left C8 radiculopathy and/or cubital tunnel syndrome as, even though the EDS was positive only for carpal tunnel syndrome, the clinical presentation of numbness/tingling primarily at the left small finger and findings of reproduction of pain down the LUE with palpation at the base of the cervical spine and the negative Durkan and Phalen maneuvers are not consistent with carpal tunnel syndrome. He notes that findings on EDS are often late findings and recommends MRI for clarification of pathology. He also suspects that the carpal tunnel syndrome is subclinical and, nevertheless, he will have the patient try a left wrist brace to see if the symptoms improve. 8/6/14 medical report identifies that the area of radiation, numbness, and tingling down the LUE remains localized to the ulnar aspect of the distal left forearm and left small and ring fingers. PT is helpful, but seems temporary. Patient feels like the left middle fingers is going to fall off and left shoulder is going to come loose as well as decreased left hand strength. Deep

palpation at the left paracervical/upper trapezius region again produces radiating pain down the LUE and increased numbness/tingling at the left small finger.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Cervical Spine: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 176-177.

Decision rationale: Regarding the request for cervical MRI, CA MTUS and ACOEM 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, the patient had electrodiagnostic studies consistent with carpal tunnel syndrome, but the provider suspects that the CTS is subclinical given the absence of subjective and objective findings consistent with that diagnosis. He also notes that EMG findings of cervical radiculopathy tend to occur later in the condition. The patient does have findings suspicious for radiculopathy with neck pain and reproduction of symptoms down the arm into the small finger with paravertebral deep palpation to the base of the cervical spine. PT was attempted and was helpful, but the effects were temporary. It appears that, given the symptoms/findings suggestive of cervical radiculopathy and/or ulnar neuropathy and the negative electrodiagnostic study findings for these conditions, an MRI would be reasonable to help determine whether or not the cervical spine is a significant pain generator so that an appropriate treatment plan can be developed. In light of the above, the requested cervical MRI is medically necessary.