MAXIMUS Federal Services

Case Number:	CM14-0121636		
Date Assigned:	08/06/2014	Date of Injury:	10/03/2008
Decision Date:	09/11/2014	UR Denial Date:	07/31/2014
Priority:	Standard	Application Received:	08/01/2014

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 & Rehabilitation and is licensed to practice in Illinois. 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 is a 50-year-old male who reported an injury due to cumulative trauma on 10/03/2006. The clinical note dated 07/24/2014 indicated diagnoses of degeneration of cervical disc, neck pain, cervical disc with radiculitis, and dystonia torsion. The injured worker is status-post Botox injections dated 07/09/2014 with 40% to 50% improved functional tolerance, improved flexibility, and fewer days off. The injured worker reported the Botox lasted for 6 months previously, and now the dystonia spasms and restrictions in range of motion were back and worse than before. The injured worker reported pain in the neck that was getting worse. The injured worker reported increased numbness, tingling in the hands bilaterally, that was worse in the morning, and sometimes when he was driving. The injured worker reported difficulty typing. He requested trigger point injections of the paracervical in October. The injured worker reported persistent spasms, muscle cramps, and contracted muscle mass along the left cervical paraspinal and trapezius muscles and lack of mobility. On physical examination, the injured worker was able to sit for 15 minutes without any limitations or evidence of pain. The injured worker had left suprascapularis fullness with large muscle spasm right anterior cervicular rotation. The injured worker's cervical spine was restricted in all planes with increased pain. The injured worker could not fully rotate his cervical spine to the left and right due to muscle guarding. There was tenderness to palpation bilaterally at the trapezius. The injured worker had a positive Spurling's bilaterally. The injured worker's hand strength was slightly diminished to the left hand. The injured worker had a positive facet- loading test, occipital neuralgia positive, and tenderness bilaterally to the C2-3, C3-4, C4-5, and C5-6 facet joints. The injured worker's treatment plan included refill of prescriptions and a trigger point injection. The injured worker's prior treatments included diagnostic imaging and medication management. The injured

worker's medication regimen was not provided for review. The provider submitted a request for MRI of the cervical spine. A Request for Authorization was not submitted for review to include the date the treatment was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of cervical spine without contrast: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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).

Decision rationale: The request for MRI of cervical spine without contrast is not medically necessary. The CA MTUS/ACOEM Guidelines state physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. 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. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI]) for neural or other soft tissue. It was indicated the injured worker had previously had an MRI of the cervical spine. It was indicated there was no observation that any new objective neurological deficits on his exam. Per the guidelines, repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The documentation submitted did not indicate the injured worker had findings that would support he was at risk for tumor, infection, fracture, neural compression or recurrent disc or herniation. It was not indicated if the injured worker had exhausted conservative therapies such as NSAIDs and physical therapy. In addition, the official MRI was not submitted for review therefore, the request for MRI of cervical spine without contrast is not medically necessary.