

Case Number:	CM14-0152837		
Date Assigned:	09/23/2014	Date of Injury:	05/22/1998
Decision Date:	10/29/2014	UR Denial Date:	08/22/2014
Priority:	Standard	Application Received:	09/18/2014

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 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 44-year-old female who was injured on 05/22/1998. The mechanism of injury is unknown. Prior medication history included Fentanyl, Avinza, Xanax, Toradol, Percocet, Tramadol, Reglan, Valium, and Neurontin. The patient underwent cervical fusion from C4 to C7 in 03/2012 which did not provide much relief. She has received trigger point injection in the past which she found helpful. Diagnostic studies reviewed include report of cervical spine x-rays performed on 08/21/2014. Lateral view demonstrated normal cervical lordosis. Disc height was well maintained at C2-3 and C3-4. Anterior plate was viewed extending from C4-C7. Makers consistent with PEEK spacers at C4-5, C5-6, and C6-7 were viewed. She had significant bone growth within the disc space at C4-5 and C5-C6. No bone growth at C6-7. Some lucency is noted at the graft site. Progress report dated 08/21/2014 documented the patient to have complaints of increased pain in her neck and bilateral upper extremities with associated weakness and numbness. She also complained of stomach pain, which she felt came from her neck due to reported prior improvement in this symptom with trigger point injections performed recent to the visit date. She also complained of worsening balance and clumsiness. On exam, the patient was reported as frail appearing. She had limited range of motion at 10 degrees of flexion; 5 degrees of extension; and approximately 30 degrees rotation bilaterally with guarding. She had diffuse tenderness over the cervical spine, shoulder, trapezius, and paraspinal muscles. She had 4/5 weakness with suspect effort reported throughout the upper and lower extremities. Deep tendon reflexes were 2+ and symmetric. The patient was diagnosed with cervical radiculopathy. The examiner noted no radiographic evidence of adjacent segment disease or hardware failure, though noted the patient had concern for adjacent disc herniation. A recommendation was made for an MRI of the cervical spine to evaluate for adjacent segment problems, though he did note symptoms and exam findings out of proportion when compared with x-ray findings.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 MRI OF THE CERVICAL SPINE/NECK W/O DYE AS OUTPATIENT: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck, MRI (Magnetic resonance imaging)

Decision rationale: The Official Disability Guidelines (ODG) lists the following indications for MRI evaluation of the cervical spine: 1) Chronic neck pain (after 3 months of conservative management), radiographs normal, neurologic signs or symptoms present; 2) Neck pain with radiculopathy if severe or progressive neurologic deficit; 3) Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present; 4) Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present; 5) Chronic neck pain, radiographs show bone or disc margin destruction; 6) Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal"; 7) Known cervical spine trauma--equivocal or positive plain films with neurological deficit; 8) Upper back/thoracic spine trauma with neurological deficit. ODG notes that repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). Of import, the ODG notes that MRI is the test of choice for patients who have had prior spine surgery. Patients with normal radiographs and neurologic signs or symptoms should undergo magnetic resonance imaging. The patient has had prior cervical fusion, as noted above. And while the medical documentation does note that the weakness on examination had "suspect effort" for her 4/5 four-extremity strength, the patient had clear symptomatic complaints of progressively worsening pain in her extremities, with associated numbness and weakness. Based on the Official Disability Guidelines (ODG) and criteria as well as the clinical documentation stated above, the request is medically necessary.