

Case Number:	CM14-0157018		
Date Assigned:	09/29/2014	Date of Injury:	04/23/2003
Decision Date:	10/28/2014	UR Denial Date:	08/25/2014
Priority:	Standard	Application Received:	09/25/2014

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 Family 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 54 year-old woman who was injured at work on 4/23/2003. The injury was primarily to her neck. She is requesting review of denial for an MRI of the Cervical Spine without Contrast. Medical records corroborate ongoing care for her injuries. Regarding the neck injury, her chronic diagnoses include: Cervical Strain with Industrial Aggravation of Underlying Cervical Spondylosis and Neurologic Compression; and Status Post Four Cervical Operative Procedures with Decompression and Fusion (C4-C7). An MRI of the Cervical Spine was last performed on 12/31/2013. The report notes difficulty with its interpretation due to "resolution" problems as described by the radiologist in the report. A CT myelogram was subsequently completed on 3/19/2014. This study demonstrated: "disk protrusion at C3-4 causing severe central stenosis and moderate cord compression. Status post anterior fusion from C5 through C7 with anterior plate in place by transfixed screws. There is moderate central canal stenosis at C5-6 due to posterior osteophyte formation which abuts the cord but does not cause compression. Degenerative changes at other levels, as described." The patient underwent a Qualified Medical Examination on 3/19/2014, which specifically recommended against any further surgical intervention on the C spine. The most recent evaluation by the Primary Treating Physician was on 7/25/2014. There were no substantive differences in the underlying symptoms or physical examination findings. The patient continues to be treated with analgesic and anti-inflammatory medications, ice, heat and a self-directed home exercise program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Magnetic resonance imaging (MRI) of the cervical spine without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation ODG Neck & Upper Back, Magnetic resonance imaging (MRI)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 165-193.

Decision rationale: The MTUS/ACOEM Guidelines describe the evaluation and management of patients with neck and upper back problems. These guidelines state that the clinician should assess for "red flag" symptoms (Pages 171 and 172). These guidelines specifically state the following: "Physical examination evidence of severe neurologic compromise that correlates with the medical history and test results may indicate a need for immediate consultation. The examination may further reinforce or reduce suspicions of tumor, infection, fracture, or dislocation. A medical history suggestive of pathology originating somewhere other than in the cervical area may warrant examination of the head, shoulder, or other areas. Cervical nerve root irritation can be demonstrated by depressing the clavicle or deeply palpating the posterior triangle of the neck. This maneuver should reproduce the patient's symptoms and signs if the cervical nerves are the source of neurologic symptoms and signs." The guidelines also describe the indications to perform special studies for diagnosis. The criteria for performing an imaging study are (Page 177 and 178): -Emergence of a red flag -Physiologic evidence of tissue insult or neurologic dysfunction- Failure to progress in a strengthening program intended to avoid surgery-Clarification of the anatomy prior to an invasive procedure Based on the information provided in the medical records, there is no clear justification for a repeat MRI for this patient. 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, recurrent disc herniation) per the stated MTUS Guidelines. There is no documentation in the records to indicate the emergence of red flag signs or symptoms. There is no documentation in support of physiologic evidence of tissue insult or neurologic dysfunction. There is no indication that the patient is in the process of being assessed for a surgical procedure and needs clarification of anatomy. Therefore, there is no evidence provided in support of an MRI of the Cervical Spine. The test is not considered as medically necessary.