

Case Number:	CM14-0159846		
Date Assigned:	10/03/2014	Date of Injury:	01/07/2004
Decision Date:	11/19/2014	UR Denial Date:	09/17/2014
Priority:	Standard	Application Received:	09/29/2014

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:

This is a 57 year old male patient who sustained a work related injury on 1/7/2004. Patient sustained the injury when a structure beam fell of his head. The current diagnoses include spinal stenosis of lumbar region and s/p cervical fusion with C7 radiculopathy and lumbar fusion. Per the doctor's note dated 08/29/14, patient has complaints of neck pain that radiated to the bilateral shoulders. Physical examination revealed moderate discomfort on palpation over the mid-cervical spine, neck pain upon extension after 20 degrees, upper extremity strength 4-/5 on the left triceps. The current medication lists include Morphine and Percocet, Zantac and clonazepam. The patient has had MRI of the right shoulder on 2/10/12 that revealed osteoarthritis of acromioclavicular joint; MRI of the lumbar spine on 2/10/12 that revealed degenerative change of the lumbar spine including spinal stenosis and foramina narrowing; MRI of the cervical spine on 6/27/12 that revealed status post anterior cervical discectomy and interbody fusion from C3 to C6, moderate spinal canal stenosis and foramina narrowing and EMG on 7/11/12 that revealed bilateral carpal tunnel syndrome. Diagnostic imaging reports were not specified in the records provided. The patient's surgical history include anterior cervical discectomy and interbody fusion from C3 to C6 on 06/22/10 and lumbar fusion on 04/28/13. Any operative/ or procedure note was not specified in the records provided. He has had a urine drug toxicology report on 4/22/14 that was positive for opioids and clonazepam. The patient has received an unspecified number of the PT visits for this injury. The patient has used a H wave unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

Decision rationale: Per the ACOEM chapter 8 guidelines cited below "For most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out." Per the ACOEM chapter 8 guidelines cited below recommend "MRI or CT to evaluate red-flag diagnoses as above, MRI or CT to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. If no improvement after 1 month bone scans if tumor or infection possible, not recommended: Imaging before 4 to 6 weeks in absence of red flags." CA, MTUS/ACOEM does not address this request for repeat cervical spine MRI. Therefore, ODG guidelines are used. Per ODG low back guidelines cited below, "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)." MRI of the cervical spine on 6/27/12 that revealed status post anterior cervical discectomy and interbody fusion from C3 to C6, moderate spinal canal stenosis and foramina narrowing. Any significant change in the patient's condition since this imaging study that would require a repeat cervical spine MRI was not specified in the records provided. Patient does not have any severe or progressive neurological deficits that are specified in the records provided. The findings suggestive of tumor, infection, fracture, neurocompression, or other red flags were not specified in the records provided. A report of a recent cervical spine plain radiograph was also not specified in the records provided. Patient has received an unspecified number of the PT visits for this injury. Previous PT notes were not specified in the records provided. The records submitted contain no accompanying current PT evaluation for this patient. A plan for an invasive procedure of the cervical spine was not specified in the records provided. The request for MRI of the Cervical Spine without contrast is not fully established for this patient.