

Case Number:	CM14-0176043		
Date Assigned:	10/29/2014	Date of Injury:	12/07/2012
Decision Date:	12/05/2014	UR Denial Date:	10/23/2014
Priority:	Standard	Application Received:	10/23/2014

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 Occupational 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:

Patient is a 43 year-old female with date of injury 12/07/2012. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 10/10/2014, lists subjective complaints as pain in the neck and bilateral shoulders. MRI of the cervical spine performed on 06/21/2013 was notable for multiple levels of desiccation from C2-3 through C6-7, loss of normal cervical lordosis, mild diffuse disc bulging at every level except C7-T1; C5-6, and C6-7 disc bulge/osteophyte complex indenting anterior subarachnoid space, both C6 nerve roots, and causing central canal and bilateral foraminal narrowing. Objective findings: Examination of the cervical spine revealed no tenderness to the bones, joints or muscles. Range of motion was mostly remarkable for decreased lateral flexion bilaterally, 3 finger breadths distance from chin to chest on flexion, functional lateral rotation bilaterally, and normal extension beyond neutral. Axial compression tests were abnormal with reproduction of typical neck pain. Axial distraction test was abnormal with relief of neck pain. Spurling's test was positive bilaterally. Sensory examination revealed pin prick sensation was 40% of normal of the left T1 dermatome and 25% on the right T1 dermatome. Diagnosis: 1) Cervical spondylosis with myelopathy 2) Cervical stenosis at C5-C7 3) Degenerative disc disease, cervical 4) Kyphosis, cervical 5) Migraine 6) Generalized anxiety disorder 7) Unspecified functional disorder of stomach 8) Chest pain, other 9) Allergic rhinitis due to pollen.

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: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177, 178, 182.

Decision rationale: The MTUS states that an MRI or CT is recommended to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. In addition, the ACOEM Guidelines state the following criteria for ordering imaging studies: 1. Emergence of a red flag, 2. Physiologic evidence of tissue insult or neurologic dysfunction, 3. Failure to progress in a strengthening program intended to avoid surgery, 4. Clarification of the anatomy prior to an invasive procedure. There is no documentation of any of the above criteria supporting a recommendation of a cervical MRI. MRI of the cervical spine without contrast is not medically necessary.