

Case Number:	CM14-0178362		
Date Assigned:	10/31/2014	Date of Injury:	09/14/2011
Decision Date:	12/11/2014	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	10/27/2014

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 Internal 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 an injured worker who sustained an injury on 09/14/2011 which resulted in a traumatic brain injury. The progress report dated 9-16-14 documented that the patient has a medical history of traumatic brain injury, obstructive sleep apnea, headaches, epilepsy, and organic brain syndrome, and depression. He does not think that he has had any seizures. His back and shoulder still hurt. His shoulder is better, but still painful. It is hard to sleep on his back. If he coughs, he has pain in the anterior right axilla. If he uses his arms and hands to make lateral transfers of materials, pain will occur in his shoulders. Reaching causes mild pain, along the inner section of the right arm and this is along the axillary side. He cannot sleep on the right side typically sleeping only 1-2 hours but notes he does not have trouble falling back asleep. It is not from pain, worry, or nocturia. He can fall back to sleep within a minute or so. He usually turns to look to the clock. He is consistently using CPAP continuous positive airway pressure. If he sits on a hard chair, he has pain along the shoulders and neck. Sometimes the pills help and sometimes they do not. The patient denied all of the psychosensory feelings that are commonly associated with seizures. There have been no events of becoming lost outside or inside the home. Physical examination revealed the patient was well developed and obese; blood pressure was 150/82 with a heart rate of 72 that was regular; he was in no acute distress; head was traumatic and normocephalic; pupils were unequal, round, and reactive to light and accommodation; and ptosis was on the right more than the left. The fundoscopic exam revealed that the discs were flat and sharp. The mouth exam showed a small oral airway with palatal elevation. The cervical lordosis was straightened. There was no pain to palpation of the paraspinous muscles or trapezius areas. The carotid pulses were decreased. There were no carotid or supraclavicular bruits. There was no adenopathy or thyromegaly. There were no neck masses. There was no chest wall deformity. The chest was clear to auscultation. There was a regular rate and rhythm. There was a

systolic murmur. There were no gallops or clicks. The peripheral pulses were slightly decreased. There were no femoral or abdominal bruits. Regarding the abdomen, there was no hepatosplenomegaly; no masses or bruits; no tenderness to palpation; bowel sounds were present and normal; abdominal and cremasteric reflexes were absent; and there was no clubbing, cyanosis, edema, or noteworthy birthmarks, rashes or bruising. There were Tinel's signs over the superficial nerves of the arms or legs. Shoulder range of motion on the right was limited and painful. There was crepitus with passive range of motion. Abduction was limited as was extension and flexion and internal rotation. All were painful. He did not have scapular winging. The exam of the left shoulder was normal. The visual fields were intact. Primary gaze was normal. The extraocular movements were saccadic, but full to confrontation. There was no nystagmus. There was no diplopia. Facial sensation was intact. Masseter strength was intact. Facial strength testing showed decreased right nasolabial fold. There was no glabellar response. Jaw jerk reflex was not present. The palate was midline. Tongue was midline. There was a gag reflex present. The sternocleidomastoid and trapezius muscles were strong. There was no torticollis. The muscle tone was increased in all, more so on the left. There was a hint of cogwheeling on the left. Bulk was reduced in the left forearm. Strength testing was normal. Rapid alternating movements were slowed on the right. No myotonia was present. Muscle spasm was absent. There were no tremors. Heel-to-shin testing was intact. The patient could do a tandem walk. The patient could walk on the heels and toes. Gait and station were wide-based and not antalgic. Light touch was intact. Pinprick was intact. Vibration was slightly decreased in the toes. Proprioception was intact. Double simultaneous stimulation was intact. Graphesthesia was intact. There was no pronator drift. The Romberg's sign was negative. Diagnoses included traumatic brain injury, organic brain syndrome, epilepsy, obstructive sleep apnea, hypertension, and shoulder pain with history of fracture of the right scapular wing, cervical and lumbar radiculopathies. Treatment plan included a request for MRI magnetic resonance imaging of the cervical spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back (updated 08/04/14)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179,181-183.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses cervical spine MRI. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints states that reliance on imaging studies alone to evaluate the source of neck or upper back symptoms carries a significant risk of diagnostic confusion (false-positive test results). Table 8-8 Summary of Recommendations for Evaluating and Managing Neck and Upper Back Complaints (pages 181-183) states that radiography are the initial studies when red flags for fracture, or neurologic deficit associated with acute trauma,

tumor, or infection are present. MRI may be recommended to evaluate red-flag diagnoses. Imaging is not recommended in the absence of red flags. MRI may be recommended to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. The progress report dated 9/16/14, documented that the patient reported no weakness in the limbs. Physical examination documented that there was no pain to palpation of the paraspinous muscles or trapezius areas. The sternocleidomastoid and trapezius muscles were strong. Strength testing was normal. There was no history of acute trauma. No x-ray radiography results were documented. MRI magnetic resonance imaging of the cervical spine was requested. No x-ray radiographs of the cervical spine were documented. MTUS and ACOEM guidelines state that x-ray radiographs are recommended as the initial studies. The first recommended imaging study is x-ray radiography. Physical examination performed on 9/16/14 did not document neck tenderness. Strength testing was normal. Nerve root compromise was not evidenced on physical examination. The request for cervical spine MRI magnetic resonance imaging is not supported by medical records and MTUS guidelines. Therefore, this request is not medically necessary.