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| Case Number: | CM14-0182025 | | |
| Date Assigned: | 11/06/2014 | Date of Injury: | 11/04/2008 |
| Decision Date: | 12/11/2014 | UR Denial Date: | 10/14/2014 |
| Priority: | Standard | Application Received: | 11/03/2014 |

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 New York. 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 injured worker reportedly was knocked down and nearly strangled while performing duties as a special education teacher on 11/04/08. In 2009 a CT of the neck and EMG confirmed issues with cervical stenosis resulting in a surgical intervention and fusion from C5 to C7 on 09/0909. This was declared a solid fusion on 06/01/10 and she was returned to work in March 2010. However she felt that the surgery had not resolved her problem and continued to experience pain at the 6-7/10 range. An EMG of the LUE on 7/29/11 by the provider was reportedly normal. Since that time the members discomfort has been worse with occupational activities and has been addressed through the use of rest, TENS, Acupuncture and the use of NSAID's (Meloxicam 7.5mg bid). Most recently Amitriptylline 10mg at bedtime had been added to augment management. At a visit 09/29/14 to her provider, she indicated that neck pain had returned and she was experiencing more pain in the antero-lateral aspect of the arm down to the hand. Additionally that there was some numbness and weakness in the arm. There was also occasional postero-lateral pain affecting the L arm. At examination hyperesthesia is reported from the C2-T1 dermatomes to light touch. Examination of the neck revealed a full pain free ROM in all directions with no palpable tenderness and no noted trigger points. Muscle testing revealed a slight decrease for L Triceps Ext (C7), Finger Flexion (C8) and Finger Abduction (T1). Spurling's Maneuver for cervical spondylosis was reported to be positive. The working diagnoses included: status post cervical spinal fusion surgery, cervical spondylosis and cervical myofascial pain syndrome. At the end of the visit the plan was to accomplish an MRI to assess for "adjacent segment syndrome and source of new radiculopathy". In dispute is the request for the MRI "Under Anesthesia". The anesthesia request was made on the RFA only.

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: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Neck & Upper Back (updated 08/04/14) Magnetic resonance imaging (MRI) Indications for imaging --MRI (magnetic resonance imaging)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 171, 172, 177, 182.

Decision rationale: The examination revealed no findings at the cervical spine other than a positive Spurling's Maneuver and hyperesthesia to light touch C2-T1. There appeared to be no dermatomal association with the primary surgical intervention and the area of sensory change. There were no specific intervening events and/or new trauma. There were no apparent ALARM symptoms. No attempt was made at conservative measures and it was not apparent that an appropriate timeframe for potential resolution had occurred (4-6 wks). At no time was there any discussion of the new findings potentially leading to the need for further surgical intervention. With no local findings in the cervical spine (spasm, restricted ROM, tenderness to palpation) and a full AROM of the upper extremities it would appear premature to undertake an MRI. The request is not medically necessary.

Anesthesia: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: UpToDate -Web Based Resource

Decision rationale: The issue of diagnostic procedures under anesthesia is not covered in the MTUS. This notation is apparent only on the RFA. At no time in the notes or summary plan of action was this consideration noted. In a review of the available medical records there was no discussion of claustrophobia, anxiety disorder or expressed concern for confined spaces. No options such as consideration for an open MRI or use of pretest benzodiazepines appear to have been considered. Anesthesia drives significant supplemental costs (equipment and anesthetist) as well as scheduling and procedural time. These would need to be explicitly considered on balance with the potential for useful new information. Anesthesia itself is not without risks, especially in a confined space. In the absence of available information on the justification and medical necessity proceeding with the MRI under anesthesia is not medically necessary.