

Case Number:	CM14-0089763		
Date Assigned:	07/23/2014	Date of Injury:	07/30/2013
Decision Date:	08/27/2014	UR Denial Date:	06/09/2014
Priority:	Standard	Application Received:	06/13/2014

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 Orthopedic Surgery, 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 38 year old female who sustained an industrial injury on 7/30/2013, from a rear end collision. A prior UR/peer review on 6/09/2014 certified the requested neurological consultation and is not medically necessary the requested MRI of the cervical spine and thoracic spine. MRI of the lumbar spine dated 1/20/2014 revealed: 1. Mild scoliosis of the lumbar spine which maybe positional. 2. L4-5: There is mild disc desiccation. There is a 2-3 mm central broad-based disc protrusion with no spinal stenosis or neural foraminal narrowing. 3. L5-S1: There are mild bilateral facet degenerative changes. There is mild disc desiccation. There is mild grade 1 retrolisthesis of L5 over S1. There is 3 mm broad based disc protrusion with no spinal stenosis or neural foraminal narrowing. The patient had an initial spine consultation on 5/19/2014, regarding complaints of lower back pain rated 5-10/10. She experiences radiating pain to her lower extremities, and numbness and tingling to the entire body. Physical examination revealed tenderness in the cervical and thoracic region, restricted cervical and lumbar ROM, 5/5 motor strength of the upper and lower extremities, intact sensation throughout the upper and lower extremities, 2/2 reflexes in the upper and lower extremities, negative Lhermitte and Spurling's test, improved axial traction, normal rhomberg and tandem, symmetrical 18 kg grip strength, negative SLR, negative Babinski and Clonus. The diagnoses are 1. Cervical, thoracic, lumbar sprain/strain, 2. Lumbar disc bulging L4-5, L5-S1, 3. Possible cervical cord compression verses either intramedullary lesion. 4. Vague neurologic abnormalities in the neck, upper extremities, lower back and lower extremities with intermittent numbness and tingling of both hands and both feet. Recommendations were neurologist consult and MRI of the brain, cervical, thoracic, and lumbar spine with/without gadolinium. MRI of the cervical spine dated 5/27/2014 provided the impressions: 1. Slight decreased conspicuity of the abnormal T2-weighted hyperintensity within the cord at the C2 level. While this could reflect sequelae from

prior cord contusion and may reflect developing myelomalacia, the possibility of a resolving area of inflammation or demyelination is raised. Continued follow-up is recommended. At this time, consider correlation with a contrast enhanced examination. Follow-up could be performed in six months on the high-field MRI of the brain as well. 2. Mild reversal of the normal lordosis of the cervical spine. 3. No evidence of significant disc height loss or disc protrusion. There is no central stenosis or foraminal narrowing at any level. The PTP progress report dated 6/9/2014 documents the patient returns regarding her neck and back. She continues with neck pain, numbness and tingling and heaviness is unchanged. On physical examination, she has some spasms of the cervical spine, pain radiates up to the head, decreased ROM, lumbar spine stiffness and spasm, and she also has complaints of diffuse numbness and tingling throughout her arms and legs. Diagnostic impressions: 1. Cervical spine cords contusion at C2 level with numbness and tingling in bilateral upper extremities. The patient did have numbness and tingling in the lower extremity which has gotten better. There are cervical spine spasms. 2. Lumbar spine sprain/strain with spasm with grade I retrolisthesis of L5 over S1 3 mm disc bulge causing no neuroforaminal narrowing.

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, with and without gadolinium: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Diagnostic Guidelines Neck & Upper Back Chapter, MRI.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-8. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck, Magnetic resonance imaging (MRI).

Decision rationale: The guidelines state the criteria for ordering imaging studies are: Emergence of a red flag; Physiologic evidence of tissue insult or neurologic dysfunction; Failure to progress in a strengthening program intended to avoid surgery; and Clarification of the anatomy prior to an invasive procedure. This patient has already undergone an MRI of the cervical spine. In addition, the medical records do not establish progressive neurological deficit, there is no evidence of an emergence of a red flag, and the patient is not pending invasive procedure. Furthermore, the patient has been authorized to undergo a neurology consult, to evaluate her vague neurological complaints. The ODG states 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), which has not been revealed in this case. Given the patient's normal neurological examination, MRI study is not indicated, and the results of the neurological consultation should be obtained prior to considering any further diagnostic studies. The medical necessity of a cervical MRI is not medically necessary.

MRI of the thoracic spine, with and without gadolinium: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, MRI.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-8. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back, MRIs (magnetic resonance imaging).

Decision rationale: According to the ACOEM guidelines, the criteria for ordering imaging studies are: Emergence of a red flag; Physiologic evidence of tissue insult or neurologic dysfunction; Failure to progress in a strengthening program intended to avoid surgery; and Clarification of the anatomy prior to an invasive procedure. The medical records do not establish progressive neurological deficit, there is no evidence of an emergence of a red flag, and the patient is not pending invasive procedure. According to the medical records, prior diagnostic studies included a cervical and lumbar MRI studies. The Official Disability Guidelines state imaging indications for MR imaging of the thoracic spine is evidence of thoracic spine trauma with neurological deficit. However, physical examination documents an entirely normal neurological examination. There is no evidence of trauma or progressive neurological deficits or significant change in clinical findings. The results of the neurological consultation should be obtained prior to considering any further diagnostic studies. Therefore, the request for MRI of the Thoracic Spine is not medically necessary.