

Case Number:	CM14-0197168		
Date Assigned:	12/05/2014	Date of Injury:	01/30/2014
Decision Date:	01/28/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	11/24/2014

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:

The applicant is a represented [REDACTED] employee who has filed a claim for neck pain and carpal tunnel syndrome reportedly associated with an industrial injury of January 30, 2014. In a Utilization Review Report dated November 18, 2014, the claims administrator failed to approve request for cervical MRI imaging. Non-MTUS ODG Guidelines on the same were endorsed. The claims administrator alluded to progress notes of November 13, 2014 and October 14, 2014 in its denial. Overall rationale was quite sparse. The applicant's attorney subsequently appealed. Electrodiagnostic testing of May 23, 2014 was interpreted as negative, with no evidence of right-sided carpal tunnel syndrome and no evidence of right-sided cervical radiculopathy. On July 14, 2014, the applicant reported ongoing complaints of neck pain radiating into the right hand with associated numbness, tingling, weakness, reportedly attributed to cumulative trauma at work from repetitive usage of the right arm. Manipulative therapy, massage therapy, interferential therapy, infrared therapy, and therapeutic exercise were endorsed, along with a rather proscriptive 5-pound lifting limitation. It did not appear that the applicant was working with said limitation in place. On July 21, 2014, the applicant again reported ongoing complaints of neck pain radiating into the right upper extremity. On July 9, 2014, the applicant reported persistent complaints of right upper extremity discomfort, 6/10. Diffuse myofascial tenderness was noted about the trapezius, shoulder, upper arm, elbow, and forearm. Reflexes were symmetric. Grip strength was grossly intact with left-sided grip strength greater than the right noted subjectively. Diclofenac was endorsed. The applicant was reportedly working with restrictions in place, it was stated on this occasion. The applicant was also using Prozac for depression. Cyclobenzaprine was dispensed. In an applicant questionnaire dated September 10, 2014, the applicant stated that she was employed. In a September 24, 2014 progress note, the applicant reported ongoing complaints of neck pain radiating into the right arm, 6/10. The

applicant stated that she was working and had missed approximately 10 days of work since the industrial injury owing to flares of severe pain. 4+ to 5-/5 right upper extremity strength was appreciated with some hyposensorium noted about the right side. A positive Spurling maneuver was noted. The applicant was asked to obtain a general orthopedic consultation and an MRI of the cervical spine. The applicant was asked to continue naproxen and Prozac. In an orthopedic consultation dated September 15, 2014, the applicant reported ongoing complaints of shoulder, wrist, and elbow pain. The applicant was asked to obtain MRI imaging of the shoulder, elbow, and wrist. The applicant was given diagnoses of shoulder bursitis, shoulder impingement syndrome, ulnar neuropathy, medial epicondylitis, and de Quervain's tenosynovitis. On October 10, 2014, the applicant was placed off of work, on total temporary disability. MRI imaging of the cervical spine was sought. 4+/5 to 5-/5 right upper extremity strength was appreciated. The attending provider seemingly suggested that he would keep the applicant off of work until the applicant obtained a cervical MRI to search for a disk herniation. 6-9/10 pain was appreciated in one section of the report and 8-9/10 pain in another section of the note. On October 14, 2014, additional chiropractic manipulative therapy, massage therapy, interferential stimulation, and infrared therapy was sought. In an appeal letter dated October 21, 2014, the applicant's orthopedist stated that he objected to the cervical MRI denial and stated that he was intent on obtaining cervical MRI imaging to search for a possible radiculopathy which could theoretically be amenable to more definitive treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI cervical: Overturned

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

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

Decision rationale: As noted in the MTUS Guideline in ACOEM Chapter 8, Table 8-8, page 182, MRI imaging of the cervical spine is recommended to validate diagnosis of nerve root compromise, based on clear history and physical exam findings, in preparation for an invasive procedure. In this case, the requesting provider, an orthopedist, did suggest that the applicant's presentation of neck pain radiating into the right arm with associated hyposensorium noted about the same and some diminution of right upper extremity strength, was suggestive of an active cervical radiculopathy process. The requesting provider suggested (but did not clearly state) that he would act on the results of the proposed MRI and/or consider definitive intervention based on the outcome of the same. Therefore, the request is medically necessary.