

Case Number:	CM14-0198755		
Date Assigned:	12/09/2014	Date of Injury:	09/20/2011
Decision Date:	01/22/2015	UR Denial Date:	11/12/2014
Priority:	Standard	Application Received:	11/26/2014

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 Physical Medicine Rehab, has a subspecialty in Pain Medicine, Spinal Cord Medicine and is licensed to practice in Massachusetts. 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 claimant has a history of a work injury occurring on 09/20/11. Treatments included an anterior cervical decompression and fusion in November 2011. She had ongoing neck pain and a CT scan in November 2013 showed findings of heterotopic ossification with mild right sided spinal cord compression without instability on flexion/extension x-rays. She was seen on 07/07/14. A CT SPECT scan of the cervical spine in June 2014 had shown findings of a possible nonunion. She was having ongoing neck pain with stiffness and muscle spasms. Pain was radiating into her arms. Physical examination findings included decreased cervical spine range of motion. A trigger point injection was performed. Norco, tramadol, Colace, and Lidoderm were prescribed. She was seen for a neurosurgery evaluation on 10/15/14. Her history of injury and treatments was reviewed. She was having ongoing cervical spine pain and stiffness with decreased range of motion. She was having right hand numbness and weakness. Treatments had included medications, trigger point injections, and massage therapy. She was having difficulty performing home exercise home exercises due to pain. Physical examination findings included decreased cervical spine range of motion with muscle spasm. There was an absent Tinel test. She had lumbar spine muscle spasm. There was decreased right hand and foot sensation. Authorization for additional testing was requested. Consideration of revision cervical spine surgery is referenced.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI, Cervical Spine: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic):Magnetic Resonance Imaging (MRI) Other Medical Treatment Guideline or Medical Evidence: American College of Radiology ACR Appropriateness Criteria: Chronic Neck Pain, 2013

Decision rationale: The claimant is more than 3 years status post work-related injury and continues to be treated for chronic neck pain. She underwent an anterior cervical decompression and fusion in November 2011. Testing has included a CT scan showing heterotopic ossification affecting the right side of her spinal cord, plain film x-rays without instability, and a CT SPECT scan showing a possible nonunion. She has right upper extremity symptoms with numbness and weakness with physical examination findings including not only right upper extremity, but right lower extremity sensory loss as well. In this case, the claimant has potentially multifactorial symptoms with findings suggestive of spinal cord involvement. Revision cervical spine surgery appears likely.MRI imaging of the cervical spine is valuable for clarification of anatomy prior to surgery and is the test of choice for patients who have had prior surgery.Therefore the requested cervical spine MRI was medically necessary.

CT Scan Cervical Spine: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic): Computed Tomography (CT)

Decision rationale: The claimant is more than 3 years status post work-related injury and continues to be treated for chronic neck pain. She underwent an anterior cervical decompression and fusion in November 2011. Testing has included a CT scan showing heterotopic ossification affecting the right side of her spinal cord, plain film x-rays without instability, and a CT SPECT scan showing a possible nonunion. A repeat CT scan is not routinely recommended, and should be reserved for a significant change in symptoms and / or findings suggestive of significant pathology where MRI is contraindicated. In this case, there is no contraindication to MRI scanning and therefore the requested repeat cervical spine CT scan was not medically necessary.

ENG/NCV; Bilateral Upper Extremities: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Neck and Upper Back (Acute & Chronic), Electromyography (EMG) (2) Neck and Upper Back (Acute & Chronic), Nerve conduction studies (NCS) Other Medical Treatment Guideline or Medical Evidence: AANEM Recommended Policy for Electrodiagnostic Medicine

Decision rationale: The claimant is more than 3 years status post work-related injury and continues to be treated for chronic neck pain. She underwent an anterior cervical decompression and fusion in November 2011. Testing has included a CT scan showing heterotopic ossification affecting the right side of her spinal cord, plain film x-rays without instability, and a CT SPECT scan showing a possible nonunion. She has right upper extremity symptoms with numbness and weakness with physical examination findings including not only right upper extremity, but right lower extremity sensory loss as well. Nerve conduction testing is recommended in patients with clinical signs of CTS who may be candidates for surgery. Needle electromyography (EMG) may be helpful as part of electrodiagnostic studies which include nerve conduction studies. In this case, the claimant has potentially multifactorial symptoms with findings suggestive of spinal cord involvement. Revision cervical spine surgery appears likely. Authorization for additional imaging has been requested which may clarify her condition. When seen by the requesting provider, there was a negative Tinel test and no documented neurological examination that would support the need for obtaining electrodiagnostic testing.