

Case Number:	CM14-0201478		
Date Assigned:	12/11/2014	Date of Injury:	03/24/2007
Decision Date:	01/28/2015	UR Denial Date:	11/13/2014
Priority:	Standard	Application Received:	12/02/2014

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 injured worker (IW) is a 38-year-old man with a date of injury of March 24, 2007. The mechanism of injury was not documented in the medical record. The injured worker's working diagnoses are status post laminectomy and microdiscectomy, left L5-S1 on April 5, 2007; status post exploration with foraminotomy and discectomy at L5-S1 on April 30, 2008, with instability at L5-S1; cervicothoracic strain/arthrosis/discopathy with central and foraminal stenosis; possible bilateral thoracic outlet syndrome; left cubital syndrome, per nerve conduction velocities; bilateral shoulder probable multidirectional instability with secondary impingement; dental diagnoses; sleep disturbance; psychiatric diagnoses; and internal medicine diagnoses. MRI of the cervical spine dated January 6, 2012 documented muscle spasms; disc desecration and 2-3 mm annular disc bulge at C4-C5 with impingement upon subarachnoid space; at C5-C6, a 1 -2 mm annular bulge, central and foraminal with mild stenosis; and C6-C7, a 1-2 mm annular bulge. Pursuant to a progress note dated November 5, 2014, the IW has been authorized for acupuncture and pain management. Recent request for surgery of the lumbar spine has been denied. The IW complains of sharp pain in the mid back that radiates anteriorly around the chest. He had a previous MRI of the cervical spine that showed nerve encroachment. Objective physical findings reveals critically positive Spurling's and formainal compression test on the left, with numbness only into the hand. On the right side, he had sharp pain into the hand. Current medications were not documented. The treatment plan indicates that a possible epidural will be considered. The IW is participating in a home exercise program. The current request is for MRI 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 72141: 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 and Upper Back (updated 8/4/14), Magnetic resonance imaging (MRI)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Neck Section, MRI.

Decision rationale: Pursuant to the Official Disability Guidelines, MRI cervical spine is not medically necessary. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The indications for magnetic resonance imaging are enumerated in the Official Disability Guidelines. For details see the Official Disability Guidelines. In this case, the date of injury is October 8, 2013. The injured worker's working diagnoses are status post right elbow contusion; status post right wrist contusion; possible right carpal tunnel and/or cubital tunnel syndrome; lumbosacral strain/arthrosis/discopathy with probable neural encroachment; right knee strain with possible medial meniscal tear; a compensatory left knee strain with patellofemoral syndrome/arthrosis; exacerbation headache; resolved gastrointestinal complaints; and sleep disturbance secondary to pain. A handwritten progress note dated November 6, 2014 mentions worsening TS/CS pain. The injured worker had an MRI of the cervical spine performed January 6, 2012. It showed muscle spasm, disk desiccation and a 2 to 3 mm annular disc bulge at C4 - 5 with impingement upon the subarachnoid space. At C5 - 6, a 1 to 2 mm annular bulge, central and foraminal mild stenosis. At C6 -7, 1 to 2 mm annular bulge. The dictated progress note dated November 5, 2014 does not contain any subjective cervical complaints, although a prior MRI of the cervical spine was mentioned. Objective findings were notable for numbness into the right-hand. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms or findings suggestive of significant pathology. There were no new significant subjective findings or findings suggestive of significant pathology. Consequently, absent the appropriate clinical documentation and more importantly, a clinical rationale for repeating an MRI of the cervical spine, MRI the cervical spine is not medically necessary.