

Case Number:	CM14-0053096		
Date Assigned:	07/07/2014	Date of Injury:	04/13/2010
Decision Date:	04/20/2015	UR Denial Date:	03/21/2014
Priority:	Standard	Application Received:	04/21/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California, Indiana, New York
Certification(s)/Specialty: Internal Medicine

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 is a 43-year-old male, who sustained an industrial injury on April 13, 2010. The diagnoses have included status post lumbar hardware removal and exploration of fusion on January 15, 2013, status post L5-S1 TLIF on September 29, 2011, cervical spondylosis and lateral epicondylitis right elbow. Treatment to date has included opioids, four view X-rays of cervical spine and four view X-rays of lumbar spine. Currently, the injured worker complains of back pain that radiates into his legs and increased neck pain that radiates into his bilateral shoulders and suboccipital region resulting in severe headaches. In a progress note dated February 26, 2014, the treating provider reports examination of the neck reveals tenderness in the cervical region decreased range of motion and positive Spurling's test bilaterally, low back exam revealed well-healed incision, active muscle spasms in the upper lumbar spine with guarding upon palpation and limited range of motion due to pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Cervical Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 165.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. 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. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness and no neurologic findings do not need imaging. Patients who do not fall into this category should have a three view cervical radiographic series followed by a computer tomography (CT). The indications for imaging are enumerated in the Official Disability Guidelines. Indications include, but are not limited to, chronic neck pain (after three months conservative treatment), radiographs normal neurologic signs or symptoms present; neck pain with radiculopathy if severe or progressive neurologic deficit; etc. 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). The criteria for ordering an MRI of the cervical spine include the emergence of a red flag, physiologic evidence of tissue insult when nerve impairment, failure to progress in a strengthening program intended to avoid surgery and clarification of anatomy prior to surgery. In this case, the injured workers working diagnoses are that both lumbar hardware removal and exploration of fusion January 15, 2013; status post L5 - S1 TLIF September 29, 2011; neuropathic leg pain; cervical spondylosis; and lateral epicondylitis). A February 26, 2014 progress note shows the injured worker complains of back pain, neck pain that radiates both shoulders (subjectively). Objectively there is decreased sensation in the C6 dermatome but no significant neurologic abnormalities were noted. Muscle strength was normal bilateral upper extremities and no additional neurologic evaluation was documented. The treating physician requested an MRI of the cervical spine to rule out nerve root injury. Utilization review indicates an attempt to contact the treating physician was made for additional information. The additional information was not received. There were no red flags or physiologic evidence of tissue insult with nerve impairment or a failure to progress in a strengthening program documented in the medical record. There was no documentation of conservative treatment in medical record. Consequently, absent clinical documentation with red flags or physiologic evidence of tissue insult with nerve impairment and a failure to progress in a strengthening program (conservative treatment), MRI cervical spine is not medically necessary.