

Case Number:	CM15-0164637		
Date Assigned:	09/02/2015	Date of Injury:	03/01/2011
Decision Date:	10/05/2015	UR Denial Date:	08/07/2015
Priority:	Standard	Application Received:	08/21/2015

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 66 year old female, who sustained an industrial injury on March 1, 2011. The injured worker was diagnosed as having cervical spondylostenosis. Treatment to date has included traction, rhizotomy, home exercise program (HEP) and pain management. A progress note dated January 5, 2015 provides the injured worker complains of chronic neck and low back pain. Physical exam notes no localizing motor deficits. There is a request for magnetic resonance imaging (MRI) and CAT scan.

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: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section, MRI cervical spine.

Decision rationale: Pursuant to the ACOEM and the Official Disability Guidelines, MRI cervical spine is not medically necessary. ACOEM states unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients not respond to treatment and who would consider surgery an option. 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 with 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 worker's working diagnoses are spondylosenosis. The date of injury is March 1, 2011. Request for authorization is August 4, 2015. There is a single progress note in the medical record by the treating provider dated January 15, 2015. There is no contemporaneous clinical documentation on about the date of request for authorization (August 4, 2015). According to the progress stated January 5, 2015, the injured worker has ongoing neck and back pain. The injured worker is being treated for C5 - C6 spondylosenosis per MRI cervical spine dated April 16, 2014. The injured worker uses home traction. 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). There is no documentation of a significant change in symptoms and/or objective clinical findings suggestive of significant pathology. Based on clinical information in the medical record, peer-reviewed evidence guidelines, no contemporary clinical documentation on or about the date of the request for authorization, a cervical MRI previously performed April 16, 2014 and no significant new symptoms or objective findings suggestive of significant pathology, MRI cervical spine is not medically necessary.

CT Scan Cervical Spine: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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, Computed Tomography (CT).

Decision rationale: Pursuant to the Official Disability Guidelines, computed tomography cervical spine is not recommended. Patients were alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, have no neurologic findings do not need imaging. These patients should have a three view cervical radiographic series followed by computed tomography in determining whether the

injured worker as ligamentous instability, and MRI is the procedure of choice. Indications for CT imaging include suspected cervical spine trauma, alert, cervical tenderness, paresthesias in the hands or feet; unconscious; impaired sensorium; known cervical spine trauma with severe pain, normal plain x-rays, no neurologic deficit, equivocal or positive x-rays, equivocal or positive x-rays with neurologic deficit. In this case, the injured worker's working diagnoses are spondylostenosis. The date of injury is March 1, 2011. Request for authorization is August 4, 2015. There is a single progress note in the medical record by the treating provider dated January 15, 2015. There is no contemporaneous clinical documentation on about the date of request for authorization (August 4, 2015). According to the progress stated January 5, 2015, the injured worker has ongoing neck and back pain. The injured worker is being treated for C5 - C6 spondylostenosis per MRI cervical spine dated April 16, 2014. The injured worker uses home traction. 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, and recurrent disc herniation). There is no documentation of a significant change in symptoms and/or objective clinical findings suggestive of significant pathology. Cervical spine x-rays were formed September 30, 2014. According to the utilization review, there were no abnormal findings documented. Although surgery was discussed, there is no clinical indication or rationale for computerized tomography cervical spine. As noted above, there is no contemporary clinical documentation on or about the date of request for authorization. Based on clinical information in the record, peer-reviewed evidence-based guidelines, no contemporary clinical documentation on or about the date of request for authorization, unremarkable cervical spine x-rays performed September 30, 2014 and no clinical indication or rationale for a cervical spine computerized tomography, computed tomography cervical spine is not medically necessary.