

Case Number:	CM15-0183499		
Date Assigned:	09/24/2015	Date of Injury:	02/04/2010
Decision Date:	11/09/2015	UR Denial Date:	08/20/2015
Priority:	Standard	Application Received:	09/17/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 41-year-old female, with a reported date of injury of 02-04-2010. The diagnoses include unspecified C5-7 level spinal cord injury, shoulder joint pain, radiculopathy due to cervical disc disorder, and anxiety disorder. Treatments and evaluation to date have included a radiofrequency neuro-ablation procedure in 12-2011, Xanax (caused headaches), Ativan, and Mirtazapine. The diagnostic studies to date have not been included in the medical records. The medical report dated 07-16-2015 indicates that the injured worker reported that her left shoulder was still painful. She reported that there was tightness in the trapezius and around the shoulder girdle. The injured worker also reported that her right hip felt sore, and she felt that the right-side of her body had lost functionality. It was noted that the injured worker had tingling in the left arm and hand and a burning sensation in the left trapezius. There was documentation that the injured worker had an injury at C5-7 with spinal cord injury. The physical examination showed reduced sensation to soft touch of the bilateral forearm, left greater than right and bilateral lower extremities. The treating physician noted that the injured worker continued to have right hemiparesis, and was wheelchair bound. An updated MRI of the cervical spine was recommended to evaluate if there were changes in her cervical status. It was noted that the injured worker had an MRI of the cervical spine in 2012; however, the report was not included. The injured worker's work status was not indicated. The treating physician requested an MRI of the cervical spine without contrast. On 08-20-2015, Utilization Review (UR) non-certified the request for an MRI of the cervical spine without contrast.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI (magnetic resonance imaging) cervical without contrast: Overturned

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) Chapter, under Magnetic resonance imaging (MRI).

Decision rationale: The patient presents with neck pain. The request is for MRI (MAGNETIC RESONANCE IMAGING) CERVICAL WITHOUT CONTRAST. The request for authorization is dated 07/17/15. Physical examination reveals motor 0/5 right deltoid, 1/5 right ext rot. of shoulder, 3/5 right hip flex, 5-/5 right tricep/bicep, 3/5 right grip strength. Balance and gait - wheelchair bound. DTRs - R>L (3+ right, 2+ left). The patient's assessment includes C5-C7 level spinal cord injury, 10/16/14. The patient continues to have a right hemiparesis. She is essentially wheelchair bound, as she needs assistance with transfers. The patient is starting to have numbness and tingling into the left ulnar, median and C6-7 distributions. She is having increased paresthesias into the right ulnar distribution. The patient's work status is not provided. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8, pages 177-178 states: "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option." ODG-TWC Guidelines, Neck and Upper Back (Acute & Chronic) Chapter, under Magnetic resonance imaging (MRI) Section states, "Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation)." Per progress report dated 07/16/15, treater's reason for the request is "to evaluate if there are changes in her cervical status as her last MRI was from 2012 prior to her cervical surgery." Per QME report dated 04/08/15, examiner states, Once the rhizotomy took place the patient then suffered irreversible damage to her spinal cord and left her in her current situation, which is very different than she was prior to the rhizotomy being performed. In this case, the patient has suffered a C5-C7 level spinal cord injury subsequent to her last MRI. Physical examination reveals significant findings or significant pathology. The request appears to meet guidelines indication for a repeat MRI. Therefore, the request IS medically necessary.