

Case Number:	CM15-0189681		
Date Assigned:	10/01/2015	Date of Injury:	03/29/2011
Decision Date:	11/09/2015	UR Denial Date:	09/10/2015
Priority:	Standard	Application Received:	09/25/2015

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: Connecticut, California, Virginia
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 64 year old male who sustained an industrial injury on 03-29-2011. On 06-29-2012, he underwent cervical spine surgery. He developed complications which led to a following surgery on 12-11-2014. According to a progress report dated 07-13-2015, the injured worker reported that on 06-30-2015, that he fell down due to sharp pain in his upper neck and had nausea and vomiting. He was out of his pain medications. He was taken to the Emergency Department where imaging was performed. Since his fall, he developed worsening neck pain and his right arm had increased weakness in the hand with numbness. Physical examination demonstrated a well-healed cervical incision, tenderness to palpation of the cervical thoracic junction. His right arm strength was "basically unchanged" with weakness in his grip and finger abduction, adduction and opposition. This was all present prior to the surgery according to the provider. He had diminished sensation over the right hand diffusely. He ambulated well. The provider noted that the computed tomography scan did not demonstrate any significant changes and that it appeared to be developing a solid fusion. He had multilevel cervical spondylosis and foraminal stenosis, but intraoperatively the foraminotomies appeared to have a nice decompression at each left performed including C7-T1. Nerve conduction velocity studies a couple of months back revealed evidence of ulnar nerve entrapment and evidence of possible radiculopathy. Recommendations included a repeat electrodiagnostic study with electromyography and nerve conduction velocity studies and x-rays. He had been having some fainting spells, but appeared to be due to poor appetite and not eating well. He was to follow up with his primary care physician for this issue. Diagnoses included cervical spondylosis with

myelopathy, cervical radiculopathy, ulnar nerve entrapment and status post cervical spinal fusion. According to a progress report dated 08-26-2015, the injured worker was feeling better. His medication intake had decreased. He seemed to need his collar intermittently to help with his neck pain. Arm pain was "improved". His strength was also "improving" in the right arm. The provider noted that anterior posterior, lateral, flexion and extension imaging of the cervical spine accident showed no changes in his cervical disc degeneration and placement of his instrumentation. There was no movement upon flexion extension. He did have a chronic cervical kyphosis. Assessment included status post C1 laminectomy, C3 to T2 laminectomies and fusion fixation for cervical myeloradiculopathy stable. The provider noted that the injured worker appeared to be doing well and improving. The provider noted that significant neck discomfort may be due to sagittal imbalance and from his chronic cervicalgia and cervical spondylosis and that it would require a major operation of possible osteotomies and even occipital cervical fixation. This was not recommended at this time. The injured worker was to start physical therapy and follow up in 6 weeks with cervical spine x-rays. On 09-10-2015, Utilization Review non-certified the request for x-rays of the cervical spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-rays of the 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) Neck and Upper Back Procedure Summary online version (updated 6/25/2015), Indications for imaging-X-rays (AP, lateral, etc).

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

Decision rationale: Per the MTUS ACOEM Guidelines, MRI may be considered in cases where red flags are present or in cases where evidence of tissue injury or neurologic dysfunction are present, failure in strengthening program to avoid surgery, or to clarify anatomy prior to operative intervention/invasive procedures. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic exam are sufficient evidence to warrant imaging studies if symptoms persist. In this case, serial films in the post operative management of the patient have been obtained, and there are no appreciable changes noted to warrant additional films as requested. It appears that this was discussed between the utilization reviewer and the treating physician. While future films may be indicated for continued monitoring of the patient's clinical situation, the request for repeat films at this time is not considered medically necessary.