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| Case Number: | CM15-0200522 | | |
| Date Assigned: | 10/15/2015 | Date of Injury: | 07/09/2015 |
| Decision Date: | 11/24/2015 | UR Denial Date: | 09/21/2015 |
| Priority: | Standard | Application Received: | 10/13/2015 |

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: North Carolina
 Certification(s)/Specialty: Family Practice

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 46 year old female with an industrial injury dated 07-09-2015. A review of the medical records indicates that the injured worker is undergoing treatment for cervical radiculopathy and concussion with loss of consciousness. According to the progress note dated 09-03-2015, the injured worker reported severe right sided headaches, severe neck pain and numbness and pain with radiation into the upper extremities. Objective findings (09-03-2015) revealed tenderness, diminished reflexes at both triceps and biceps, diminished sensory in a bilateral C6-C7 distribution, and diffuse cervical spine spasm with limited range of motion. The injured worker cervical spine flexion was about 20 degrees, extension of 10 degrees and bilateral rotation of 10 degrees. Treatment to date was not documented in report. The treating physician impression was post-concussion syndrome and possible nerve impingement syndrome of the neck. The treatment plan included objective diagnostic evaluation. The utilization review dated 09-21-2015, non-certified the request for Magnetic Resonance Imaging (MRI) of head and Electromyography (EMG) - Nerve conduction velocity (NCV) of bilateral upper extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of head: 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), Head, MRI.

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

Decision rationale: The California MTUS and the ACOEM do not directly address the requested service. The ODG does not recommend neuroimaging for patients who have sustained a concussion/mild TBI beyond the first 72 hours unless there is deterioration of the patient's condition or red flags on exam. The request is for a MRI post the first 72 hours. There is no deterioration or red flags noted on exam. Therefore the request is therefore not medically necessary.

EMG/NCV of bilateral upper extremities: Upheld

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

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

Decision rationale: The ACOEM chapter on neck and upper back complaints and special diagnostic studies states: Criteria for ordering imaging studies are: Emergence of a red flag- Physiologic evidence of tissue insult or neurologic dysfunction- Failure to progress in a strengthening program intended to avoid surgery. Clarification of the anatomy prior to an invasive procedure. 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 examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. The provided documentation does not show any signs of emergence of red flags. There is evidence of neurologic dysfunction on exam. There is no mention of planned invasive procedures. There are no subtle neurologic findings listed on the physical exam. Conservative treatment has not been exhausted. For these reasons criteria for special diagnostic testing has not been met per the ACOEM. Therefore the request is not medically necessary.

