

Case Number:	CM15-0204151		
Date Assigned:	10/20/2015	Date of Injury:	09/24/2012
Decision Date:	12/02/2015	UR Denial Date:	10/06/2015
Priority:	Standard	Application Received:	10/16/2015

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: Emergency 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 51 year old male who sustained an industrial injury on 09-24-2012. Medical records indicated the worker was treated for cervical myofascial strain, cervical facet arthropathy, lumbar radiculopathy, lumbar facet arthropathy, right shoulder impingement syndrome, lumbago, cervicgia, thoracic myofascial strain, lumbar myofascial strain. According to provider notes 09-18-2015, the worker complains of constant aching neck pain, headaches from the base of the skull to the top of the head. He complains of constant radiating aching and numbness that radiates down the bilateral upper extremities to the bilateral wrists, right worse than left. The right hand has increased numbness and he has difficulty grasping objects. He currently rates the pain at a 9 on a scale of 0-10 at the time of evaluation. Dermatomes C2-S1 were intact to light touch and pinprick. He had 5 out of 5 strength with passive range of motion in all major joints and myotomes C5-S2 right and left in upper and lower extremities with no structural deformities except there was moderate limitation of right shoulder abduction with passive range of motion. Active range of motion was to about 70 degrees. Hypertonicity was present in the bilateral trapezii, paraspinals and bilateral C3-C5, L1-L5. He was tender to palpation in the bilateral trapezii, paraspinals, bilateral C3-C6, L1-L5. The worker had limited range of motion. His last MRI of the cervical spine (10-02-2013) showed degenerative disc disease and facet arthropathy with retrolisthesis, C3-C4 and C4-C5 with minimal chronic superior endplate compression T3 and T4, and canal stenosis including C4-C5 moderate, C5-C6 mild to moderate, and C6-C7 mild to moderate canal stenosis and neural foraminal narrowing include C6-C7 moderate bilateral neural foraminal narrowing. The plan of

treatment included medications, and a MRI of the cervical spine. A request for authorization was submitted for MRI of the cervical spine. A utilization review decision 10-06-2015 non-certified the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI 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, Magnetic resonance imaging (MRI).

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

Decision rationale: The requested MRI of the cervical spine, is not medically necessary. CA MTUS, ACOEM 2nd Edition, 2004, Chapter 8, Neck and Upper Back Complaints, Special Studies and Diagnostic and Therapeutic Considerations, Pages 178-179, recommend imaging studies of the cervical spine with "Unequivocal objective findings that identify specific nerve compromise on the neurological examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option". The injured worker has constant aching neck pain, headaches from the base of the skull to the top of the head. He complains of constant radiating aching and numbness that radiates down the bilateral upper extremities to the bilateral wrists, right worse than left. The right hand has increased numbness and he has difficulty grasping objects. He currently rates the pain at a 9 on a scale of 0-10 at the time of evaluation. Dermatomes C2-S1 were intact to light touch and pinprick. He had 5 out of 5 strength with passive range of motion in all major joints and myotomes C5-S2 right and left in upper and lower extremities with no structural deformities except there was moderate limitation of right shoulder abduction with passive range of motion. Active range of motion was to about 70 degrees. Hypertonicity was present in the bilateral trapezii, paraspinals and bilateral C3-C5, L1-L5. He was tender to palpation in the bilateral trapezii, paraspinals, bilateral C3-C6, L1-L5. The worker had limited range of motion. His last MRI of the cervical spine (10-02-2013) showed degenerative disc disease and facet arthropathy with retrolisthesis, C3-C4 and C4-C5 with minimal chronic superior endplate compression T3 and T4, and canal stenosis including C4-C5 moderate, C5-C6 mild to moderate, and C6-C7 mild to moderate canal stenosis and neural foraminal narrowing include C6-C7 moderate bilateral neural foraminal narrowing. The treating physician has not documented evidence of an acute clinical change since a previous imaging study. The criteria noted above not having been met, MRI of the cervical spine is not medically necessary.