

Case Number:	CM14-0162134		
Date Assigned:	10/07/2014	Date of Injury:	09/10/1998
Decision Date:	11/07/2014	UR Denial Date:	08/29/2014
Priority:	Standard	Application Received:	10/02/2014

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the provided documents this is a 67-year-old woman with a date of injury on 9/10/96. The disputed treatment is a cervical spine x-ray is addressed in a utilization review determination letter from 8/29/14. There is a 7/29/14 medical report that indicates that it is a 1st Report of Injury, that is accompanied by a narrative of the same date indicating that the patient is being evaluated for complaints of pain in the neck, upper back, lower back, bilateral shoulders, bilateral wrist, left knee and left ankle. Complaints relating to the neck were pain rated 6/10, constant radiating to the upper back, bilateral shoulders and left arm associated with numbness, tingling, burning. She had limited range of motion. That narrative relates a long history of multiple injuries to multiple body parts including the neck with treatment over a number of years. This has included physical therapy, oral pain medications, diagnostic testing including MRIs, x-rays bone scans and electrodiagnostic studies for the back and neck and upper and lower extremities. She has seen orthopedists but has not had any surgery. For the past 3 years she had not had any diagnostic studies and had been receiving conservative care with oral medication and routine follow-up appointments with a different doctor, who has retired. She was referred to the current orthopedist for continued future medical care treatment. The report indicated that at that time the patient was not receiving any medical treatment, although a medication list included ibuprofen, Naprosyn and Carisoprodol. She was not working and was medically retired. Examination of the neck showed decreased range of motion with discomfort at the endpoints and that the patient was not tender over the spinous processes or paraspinal musculature. There were no neurologic deficits noted in the upper extremities. Diagnoses relevant to the neck were cervical spine's sprain/strain and cervical radiculopathy per patient history. There was no mention of any recent flare up or exacerbation of the patient's neck pain, no mention of any new recent trauma. The rationale given for the radiographs is that there were no current imaging

studies available. Radiographs included multiple other body parts in addition to the neck. The report did note that the patient said that medical records would be requested because she indicated that she had diagnostic studies done in the past.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical Spine X-Ray: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

Decision rationale: ACOEM guidelines indicate that the criteria for ordering imaging studies is the emergence of a red flag (this would include concern for fracture, tumor or infection), physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. In this case the patient's pain was chronic and per the documentation, stable. There has been no recent significant exacerbation; and there was no documentation of neurologic dysfunction possibly arising from the cervical spine. The only objective finding was reduced range of motion. There is no indication this patient would be a surgical candidate and there has been no recent conservative treatment except for possibly some medications. Therefore, based upon the evidence and the guidelines the radiographs of the cervical spine are not medically necessary.