

Case Number:	CM14-0212705		
Date Assigned:	12/30/2014	Date of Injury:	07/23/1991
Decision Date:	02/27/2015	UR Denial Date:	12/05/2014
Priority:	Standard	Application Received:	12/18/2014

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. 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, Indiana, New York
Certification(s)/Specialty: Internal 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 (IW) is a 51-year-old woman with a date of injury July 22, 1991. The mechanism of injury was a cumulative trauma. The injured worker's working diagnoses are cervical spondylosis radiculitis; left shoulder arthroscopy; right shoulder AC arthritis; left knee arthroscopy with DJD; right knee DJD; and low back pain. There was a sole progress report in the 18 page medical record dated November 13, 2014. Pursuant to the clinical documentation, the IW complains of neck pain, bilateral shoulder pain, low back pain, and bilateral knee pain. The IW describes her neck pain is moderate to severe. The pain radiates to her shoulder. Symptoms include swelling, burning, weakness, numbness, and tenderness. The pain is rated 4/10. Examination of the cervical spine reveals 70 degrees flexion and 70 degrees of extension with positive head compression. There is no neurologic evaluation performed. There are no neurological deficits documented. There are no other physical findings referable to the neck documented. The treating physical reports there were no records to review. X-rays of the cervical spine shows spondylosis with degenerative changes at C2-C3, C3-C4, and C5-C5. The current request is for MRI of the cervical spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of 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, Indications for Imaging

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

Decision rationale: Pursuant to the Official Disability Guidelines, MRI cervical spine is not medically necessary. Patients were alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, and have no neurologic findings do not need imaging. The indications for magnetic resonance imaging are enumerated in the Official Disability Guidelines. Indications for imaging include, but are not limited to, chronic neck pain (after three months conservative treatment), radiographs normal neurologic signs or symptoms present; pain with radiculopathy if severe or progressive neurologic deficit. In this case, the documentation includes a single medical record/progress note dated November 13, 2014. The injured worker's working diagnoses are cervical spondylosis/radiculitis; left shoulder arthroscopy; right shoulder AC arthritis; left knee arthroscopy with degenerative joint disease; right knee degenerative joint disease; and low back pain. The injured worker has complaints of pain in the neck. The physical examination is limited to range of motion with 70 of flexion and 70 of extension with positive head compression. There is no neurologic evaluation performed. There is no neurologic deficit presence in the medical record. There is no documentation of any symptoms or physical findings compatible with cervical radiculopathy or myelopathy with neurologic deficit for which a cervical MRI is clinically indicated. Consequently, absent clinical documentation to support the cervical magnetic resonance imaging scan in the absence of neurologic findings, MRI cervical spine was not necessary.