

Case Number:	CM14-0216455		
Date Assigned:	01/06/2015	Date of Injury:	11/01/1979
Decision Date:	02/25/2015	UR Denial Date:	11/25/2014
Priority:	Standard	Application Received:	12/26/2014

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 60-year-old man with a date of injury of November 1, 1979. The mechanism of injury is not documented in the medical record. The injured worker's working diagnoses are degeneration of lumbosacral intervertebral disc; displacement of lumbar intervertebral disc without myelopathy; and degeneration of cervical intervertebral disc. Pursuant to the progress note dated November 11, 2014, the IW has a long history of cervical spine pain and cervical radiculopathy. He also has complaints of chronic lower back pain. He has notes increased pain around the left side of the neck and shoulder with paresthesias running down the left arm. He also noted episode of weakness down the left leg. He finds Ibuprofen helpful as needed. Physical examination indicates there appears to be paresthesias down the left arm in a C7-T1 distribution. Discussion notes indicate the IW has not had any diagnostic testing of his neck in many years and is recommending an updated MRI of the cervical spine. The current request is for MRI without contrast 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 without contrast cervical spine: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Neck section, MRI

Decision rationale: Pursuant to the Official Disability Guidelines, MRI evaluation cervical spine without contrast 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 no neurologic findings do not need imaging. Patients who do not fall into this category should have a three view cervical radiographic series followed by feuded tomography. The indications for imaging are enumerated in the official disability guidelines. They include, but are not limited to, chronic neck pain, after three months conservative treatment, radiographs normal, neurologic signs or symptoms present; neck pain with radiculopathy is severe or progressive neurologic deficit; etc. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neural compression, recurrent disc herniation). See the guidelines for additional details. In this case, the injured worker's working diagnoses are degeneration of lumbosacral intervertebral disc; displacement of lumbar intervertebral disc without myelopathy; and degeneration of cervical intervertebral disc. The medical record was 26 pages in its entirety. The documentation states the injured worker has increased pain around the left side of the neck and shoulder with paresthesias running down the left arm. The physical examination states there appear to be "paresthesias down the left arm and the C7-T-1 distribution". Paresthesias are symptoms not objective findings. There is no muscular or neurologic examination in the medical record. Additionally. The injured worker had an MRI several years back and the treating physician wants an updated MRI. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. There are no comparison physical examinations or progress notes in the medical record. There are no significant symptoms or findings of an objective nature that warrant a repeat cervical spine MRI. Consequently, absent clinical documentation to support a repeat MRI of the cervical spine in the 24 page medical record, MRI evaluation cervical spine without contrast is not medically necessary.