

Case Number:	CM15-0110749		
Date Assigned:	06/17/2015	Date of Injury:	03/28/2011
Decision Date:	07/16/2015	UR Denial Date:	05/14/2015
Priority:	Standard	Application Received:	06/09/2015

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 70 year old female with an industrial injury dated 03/28/2011 resulting in neck pain, headaches and low back pain. Her diagnoses included neck sprain, cervical spondylosis without myelopathy, sprain of ligament of lumbosacral joint and lumbosacral spondylosis without myelopathy. Co morbid diagnosis was dyslipidemia. Prior treatment included physical therapy, cervical and lumbar MRI, pain medication, anti-inflammatory medication, muscle relaxants and acupuncture. She presents on 04/17/2015 with complaints of a flare up of neck pain described as burning and radiating to the upper back two weeks ago. She also complains of headaches and altered sleep. She continued to work. Physical exam revealed limited cervical range of motion with cervical paraspinal spasm. There was positive left cervical facet maneuver and left sub occipital myofascial trigger point. Left upper trapezius trigger point and suprascapular spasm was present. Lumbar range of motion was limited with lumbar paraspinal spasm. In the progress note dated 03/11/2015 documentation states the injured worker underwent cervical and lumbar MRI. There are no formal MRI reports in the submitted records. Treatment plan included cervical MRI to rule out progressive spinal stenosis; cervical 4-5 spinal cord indentation, discontinue naproxen, medications (Relafen, Flexeril and Prevacid) and continue with usual and customary work. The injured worker declined facet block injection. Treatment request is for MRI (Magnetic Resonance Imaging) 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 (Magnetic Resonance Imaging) of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 165.

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

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. The provided progress notes fails to show any documentation of indications for imaging studies of the neck as outlined above per the ACOEM. There was no emergence of red flag. The neck pain was characterized as unchanged. The physical exam noted no evidence of new tissue insult or neurologic dysfunction. There is no planned invasive procedure. Therefore, criteria have not been met for a MRI of the neck and the request is not medically necessary.