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| Case Number: | CM15-0116351 | | |
| Date Assigned: | 06/24/2015 | Date of Injury: | 08/04/2014 |
| Decision Date: | 07/24/2015 | UR Denial Date: | 05/22/2015 |
| Priority: | Standard | Application Received: | 06/17/2015 |

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: Texas, New York, California
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 applicant is a represented 39-year-old who has filed a claim for chronic neck and low back pain reportedly associated with an industrial injury of August 4, 2014. In a Utilization Review report dated May 22, 2015, the claims administrator failed to approve a request for cervical MRI imaging. The applicant's attorney subsequently appealed. On June 7, 2015, the applicant reported ongoing complaints of neck pain radiating to the bilateral upper extremities. Low back pain radiating to the bilateral legs were also reported. The attending provider noted that applicant was using tramadol, metformin, pravastatin, and Norvasc. The applicant had apparently alleged multifocal pain complaints secondary to cumulative trauma at work. Hyposensorium about the arm and a positive right-sided Spurling maneuver were appreciated. The attending provider stated that he believed that earlier cervical MRI imaging was nondiagnostic. The earlier cervical and lumbar MRI imaging were of poor technical quality. Repeat cervical and lumbar MRI imaging were sought on the grounds that the attending provider stated that he did not want wish to make a decision as to what treatments to pursue based on the reportedly poor quality studies. On May 12, 2015, the attending provider again appealed previously denied cervical and lumbar MRI imaging, again noting dysesthesias about the C6-C7 distributions bilaterally. A 20-pound lifting limitation was imposed. The attending provider wrote on an appeal letter of May 1, 2015 that the cervical MRI imaging at issue, if positive for isolated pathology at C6-C7, would likely compel surgical intervention.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Cervical Spine without contrast: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 5/12/15 Neck & Upper Back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

Decision rationale: Yes, the proposed cervical MRI without contrast was medically necessary, medically appropriate, or indicated here. As noted in the MTUS Guidelines in ACOEM Chapter 8, Table 8-8, page 182, MRI or CT imaging is "recommended" to validate diagnosis of nerve root compromise based on clear history and physical exam findings, in preparation for an invasive procedure. Here, the requesting provider, a spine surgeon, did write on a May 1, 2015 appeal letter that he would act on the results of the cervical MRI in question and offer the applicant surgical intervention if said MRI demonstrated significant single level pathology at C6-C7. The applicant was described as having complaints of neck pain radiating to the bilateral upper extremities with dysesthesias in the C6-C7 distribution on or around the date of the request. The attending provider maintained that previously performed cervical MRI imaging was of poor technical quality. Moving forward with the proposed cervical MRI imaging as a precursor to possible surgical intervention was, thus, indicated. Therefore, the request was medically necessary.