

Case Number:	CM15-0123006		
Date Assigned:	07/07/2015	Date of Injury:	07/16/2009
Decision Date:	08/06/2015	UR Denial Date:	06/17/2015
Priority:	Standard	Application Received:	06/25/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 male who sustained an industrial injury on 07/16/2009. The original injury affected the left small finger and required three surgical procedures. Current diagnoses include status post left fifth digit laceration followed by multiple surgeries with internal derangement and residual pain; cervical degenerative disc disease (DDD) and spondylosis at C5-7 and cervical radicular symptoms following nerve conduction study. Treatment to date has included medications. According to the progress notes dated 5/26/15, the IW reported severe pain in the neck and the left scapula radiating down the left shoulder, elbow and left small and ring fingers described as a burning sensation. He also complained of a cold sensation radiating down the left arm. The IW stated he started having neck pain radiating down the arms, worse on the left, after nerve conduction testing in 2011. On examination, range of motion was full in the cervical spine, without spasm or asymmetry. Spurling's and shoulder abduction signs were negative. There was tenderness to palpation over the midline of the cervical spine. Motor strength of the bilateral upper extremities was 5/5. Sensation and reflexes of the upper extremities were normal. Nerve conduction testing in 2011 was normal. X-rays of the cervical spine on 2/4/15 found moderate to advanced C5-6 and C6-7 degenerative disc disease and spondylosis; overall kyphotic alignment primarily secondary to the spondylosis at C5-7; and a large posterior osteophyte at C5-6. A request was made for MRI of the cervical spine to assess for significant spinal stenosis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Magnetic resonance imaging (MRI) of the Cervical Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 176-7.

Decision rationale: Regarding the request for cervical MRI, CA MTUS and ACOEM guidelines support the use of imaging for emergence of a red flag, physiologic evidence of tissue insult or neurologic deficit, failure to progress in a strengthening program intended to avoid surgery, and for clarification of the anatomy prior to an invasive procedure. Guidelines also recommend MRI after 3 months of conservative treatment. Within the documentation available for review, there is no indication of any red flags or objective findings indicative of neurologic deficit persisting despite conservative management addressing the cervical spine. In the absence of such documentation, the requested cervical MRI is not medically necessary.