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| Case Number: | CM15-0126207 | | |
| Date Assigned: | 07/10/2015 | Date of Injury: | 01/07/2004 |
| Decision Date: | 08/06/2015 | UR Denial Date: | 06/01/2015 |
| Priority: | Standard | Application Received: | 06/30/2015 |

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: 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 57-year-old male, who sustained an industrial injury on 1/7/04. Initial complaints were not reviewed. The injured worker was diagnosed as having closed head trauma with concussion resolved without residual complaints; right shoulder impingement; bilateral hip pain; upper thoracic pain; secondary depression/anxiety due to chronic pain; left shoulder pain compensable consequence due to chronic right shoulder/arm pain; aggravation of GERD/hemorrhoids due to chronic opioids. Treatment to date has included status post lumbar L4-S1 surgery (4/28/13; status post cervical C3-C6 fusion (6/22/10); psychiatric consultations; physical therapy; urine drug screening; medications. Diagnostics studies included MRI right shoulder (2/10/12); MRI lumbar spine (2/10/12; 11/16/12); MRI cervical spine (6/27/12); EMG/NCV study bilateral upper extremities (7/11/12). Currently, the PR-2 notes dated 5/8/15 indicated the injured worker was seen as a follow-up visit. He was last seen on 3/17/15. He is a status post lumbar and cervical fusion. He was recently discharged from a drug rehab center in which he was weaned off all his pain medications. He continues to complain of neck pain and low back pain with pain and parenthesizes in the upper and lower extremities, buttocks, thighs and calves. The symptoms are worse with prolonged standing, sitting and heavy lifting as well as looking up. He offers no complaints of loss of dexterity in the upper extremities. On physical examination the provider notes all incisions are well healed. He has 5/5 strength throughout the bilateral upper and lower extremities. There is tenderness to palpation over the paravertebral muscles of the lumbar spine with straight leg raise negative bilaterally. He has negative Patrick's sign bilaterally. The provider is requesting authorization of MRI (magnetic resonance imaging) of the cervical spine without contrast.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI (magnetic resonance imaging) Cervical Spine, without contrast: 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): Tables 8-1 and 8-2 and Algorithm 8-3.

Decision rationale: The MTUS/ACOEM Guidelines comment on the evaluation of patients with neck and upper back complaints. This chapter includes a discussion of the indications for imaging studies to include MRI. The clinician should document whether there is evidence for any of the red flags, which may indicate the potential for a serious underlying condition (Table 8-1). In this case, there is no evidence that the patient is experiencing any of the above cited red flag symptoms. Further, there should be evidence of a physical examination to assess for the presence of nerve root compromise. These are described in Table 8-2. In this case, there is no documentation of any physical examination findings that suggest nerve root compromise. Specifically, in the last documented office visit (5/8/2015) the patient is described as having full strength of the extremities. There is no documentation of other pertinent findings such as deep tendon reflexes, an assessment of sensation or other evidence of muscle atrophy. Algorithm 8-3 describes the process of evaluation of slow-to-recover patients with an occupational neck and upper back complaint. In this algorithm, in the absence of evidence of nerve root compromise, imaging with an MRI is not indicated. In summary, there is insufficient evidence in support of the need for an MRI of the cervical spine. There is no evidence of nerve root compromise. There is insufficient evidence for any red flag symptom. For these reasons, an MRI of the Cervical spine is not medically necessary.