

Case Number:	CM15-0147684		
Date Assigned:	08/10/2015	Date of Injury:	05/02/2012
Decision Date:	10/19/2015	UR Denial Date:	07/09/2015
Priority:	Standard	Application Received:	07/29/2015

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, 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 59 year old female, who sustained an industrial injury on May 2, 2012. A review of the medical records indicates that the injured worker is undergoing treatment for cervical spondylosis. On May 19, 2015, the injured worker reported neck pain that radiates bilaterally down the arms to the hands causing numbness, headaches, and bilateral arm pain, with numbness and weakness into the bilateral hands. The Primary Treating Physician's report dated May 19, 2015, noted the injured worker had a repeat electromyography (EMG)-nerve conduction velocity (NCV) and MRI performed. The cervical spine was noted to have tenderness throughout the midline with sensitivity in the superior region. The cervical spine range of motion (ROM) was noted to be decreased. The sensory exam was noted to show decreased pinprick sensation in the right ulnar distribution. A cervical spine MRI dated May 5, 2015, was noted to show disc degeneration and moderate loss of disc height at C5-C6 with posterior disc-osteophyte complex which caused central canal stenosis and moderate bilateral neural foraminal narrowing. The patient has had MRI of the cervical spine on 9/17/2013 that revealed disc protrusion, central canal stenosis and foraminal narrowing; moderate uncovertebral hypertrophy was noted on the right. The patient has had EMG on 5/8/2015 that revealed mild right median neuropathy. The patient has had X-ray of the cervical spine on 7/24/13 that revealed cervical spondylosis and foraminal narrowing. The physician noted the injured worker had "failed to find relief of her symptoms over the last three years despite work modifications, work furlough, and retirement". The injured worker was noted to have been treated with non-steroid anti-inflammatory drugs (NSAIDs), muscle relaxants, and narcotics, and has undergone physical therapy and one cervical

epidural steroid injection (ESI). The Physician noted the recommendation of surgery in the form of an anterior cervical discectomy and interbody fusion for decompression with iliac crest autograft at C5-C6. The injured worker's work status was noted to be retired, remaining permanent and stationary. The provider requested authorization for Norco 10/325mg #60 and a Cervical MRI. The Utilization Review (UR) dated July 9, 2015, recommended certification of the Norco 10/325mg #60 and did not certify the request for a cervical MRI. The medication list includes Norco. Per the note dated 3/19/15 the patient had complaints of headache, neck pain, numbness in face, radicular pain in bilateral upper extremity with numbness, and bilateral hand weakness. Physical examination of the cervical spine revealed tenderness on palpation, limited range of motion, negative foraminal compression test, decreased sensation in bilateral upper extremity, 5/5 strength, Patient had received cervical ESI for this injury. The patient had received an unspecified number of PT visits for this injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical MRI: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, MRI (magnetic resonance imaging).

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back (updated 06/25/15) Magnetic resonance imaging (MRI).

Decision rationale: Per the ACOEM chapter 8 guidelines cited below "For most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out". Per the ACOEM chapter 8 guidelines cited below recommend "MRI or CT to evaluate red-flag diagnoses as above, MRI or CT to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. If no improvement after 1 month bone scans if tumor or infection possible, not recommended: Imaging before 4 to 6 weeks in absence of red flags". Per ODG low back guidelines cited below, "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, neurocompression, recurrent disc herniation)". A cervical spine MRI dated May 5, 2015, was noted to show disc degeneration and moderate loss of disc height at C5-C6 with posterior disc-osteophyte complex which caused central canal stenosis and moderate bilateral neural foraminal narrowing. The patient has had MRI of the cervical spine on 9/17/2013 that revealed disc protrusion, central canal stenosis and foraminal narrowing. Significant changes in objective physical examination findings since the last study, which would require a repeat study, were not specified in the records provided. The findings suggestive of tumor, infection, fracture, or other red flags were not specified in the records provided. Patient has received an unspecified number of PT visits for this injury. Previous PT notes were not specified in the records provided. The records submitted contain no accompanying current PT evaluation for this patient. The request for Cervical MRI is not medically necessary or fully established for this patient.

