

Case Number:	CM15-0172437		
Date Assigned:	09/14/2015	Date of Injury:	01/27/2012
Decision Date:	10/13/2015	UR Denial Date:	08/03/2015
Priority:	Standard	Application Received:	09/01/2015

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: Massachusetts

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 is a 63 year old male, who sustained an industrial injury on 1-27-12. The injured worker was diagnosed as having cervical spondylosis with myelopathy. Treatment to date has included status post cervical C3-4 fusion; physical therapy; medications. Diagnostics studies included cervical spine x-rays (4-15-15; 7-15-15). Currently, the PR-2 notes dated 7-21-15 indicated the injured worker was in the office for a neurosurgery follow-up. The injured worker reports complaints of numbness in the left hand and has pain in the right scapula. The provider does include his physical examination and notes musculoskeletal "patient denies joint pain or swelling, arthritis, broken bones, positive for arm-leg weakness, back pain and arm-leg pain. Medical history notes diabetes mellitus, hypertension, reported problems with anesthesia with a surgical history of bilateral arm surgery 2012 and 2014. The provider notes x-rays (no date) show stable C3-4 fusion. A Cervical spine x-ray report was submitted dated 7-15-15 and documents an impression 1) uncomplicated post-surgical findings C3-C4. 2) Severe disc narrowing and uncovertebral joint spurring at the C5-C6 and C6-C7 levels. 3) Slight anterolisthesis on flexion and C4-C5. His plan included a request for a cervical MRI. A PR-2 dated 7-1-15 indicated the injured worker presented for a re-evaluation. He was complaining of numbness and tingling of his hands especially at night. He states he started physical therapy and has about a month of sessions worth. He documents he is currently taking Percocet 7.5-325mg every 4 when necessary and averages about 3-5 tablets a day. He currently is taking Gabapentin 300mg at night and was advised by the provider to increase this to 600mg given his complaint of paresthesias. On physical examination of the cervical spine the provider documents flexion,

extension, side bends and rotations are limited nontender, and tense over bilateral upper trapezius, rhomboids and levator scapulae. He notes the incision right cervical region is clean and dry. The right upper extremity documents manual muscle testing of the right deltoids 5 out of 5 biceps triceps, wrist extensors are 5 out of 5 with intrinsic 4 out of 5 sensation to light touch is intact with a positive Hoffman's sign and there is atrophy of the hand intrinsic noted by this provider. The left upper extremity is the same but Hoffman's sign is negative. The provider diagnosed the injured worker with cervical spinal stenosis and cubital tunnel syndrome. A Request for Authorization is dated 9-1-15. A Utilization Review letter is dated 8-3-15 and non-certification was for MRI without contrast, cervical spine. The Utilization Review non-certified the MRI of the cervical spine due to "Supportable indications for this study were not adequately identified." The provider is requesting authorization of MRI without contrast, cervical spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI without contrast, cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic), Magnetic resonance imaging.

Decision rationale: The claimant sustained a work injury in January 2012 and underwent an anterior cervical spine fusion on 04/15/15. Prior to surgery imaging had shown multilevel moderate to severe stenosis at C5-6 and C6-7 with mild to moderate stenosis at C4-5 and severe stenosis at C3-4 including findings of myelomalacia. In July 2015 he had ongoing complaints of numbness and tingling. He had started physical therapy. His gabapentin dose was increased. When this request was made, he was having left hand numbness and right scapular pain. X-rays showed findings of a stable C3-4 fusion. There was a normal neurological examination including strength, sensation, reflexes, and coordination. A repeat MRI scan of the cervical spine was requested. Guidelines recommend against a repeat cervical spine MRI that should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology such as tumor, infection, fracture, neurocompression, or recurrent disc herniation. In this case, the claimant has already had x-rays of the cervical spine after surgery without abnormal findings. There was a normal neurological examination without new injury or significant change in his condition and no identified red flags that would indicate the need for a repeat scan. The request was not medically necessary.