MAXIMUS Federal Services

Case Number:	CM15-0072429		
Date Assigned:	04/22/2015	Date of Injury:	04/15/2009
Decision Date:	05/20/2015	UR Denial Date:	03/17/2015
Priority:	Standard	Application Received:	04/16/2015

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, Indiana, New York
Certification(s)/Specialty: Internal 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 injured worker was a 46 year old female, who sustained an industrial injury, April 15, 2009. The injured worker previously received the following treatments cervical spine MRI, physical therapy with traction, cervical steroid injection, non-steroidal anti-inflammatory medications, 2 chiropractic sessions, 2 trigger point injection in the past, EMG/NCS (electrodiagnostic studies and nerve conduction studies) of the bilateral upper extremities, anterior cervical decompression and fusion at C5-C6, cervical x-ray, Flexeril, Cymbalta and Norco. The injured worker was diagnosed with status post right shoulder surgery, left shoulder bursitis tendinitis, biceps tendonitis, possible TOS left and RTC tendinosis. According to progress note of December 2, 2014, the injured workers chief complaint was neck pain getting progressively worse. The injured worker was requesting trigger point injections for the neck. The injured worker rated the pain 8 out of 10, 0 being no pain and 10 being the worse pain. The physical exam noted sensory diminishment to light touch and pinprick in the bilateral C8 dermatome, left greater than the right. The past cervical MRI was in January 6, 2014, the physician requested an updated MRI to evaluate syrinx seen on the last MRI.

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat MRI 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): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Section, MRI.

Decision rationale: Pursuant to the ACOEM and the Official Disability Guidelines, repeat MRI cervical spine is not medically necessary. ACOEM states unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients not respond to treatment and who would consider surgery an option. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness and no neurologic findings do not need imaging. Patients who do not fall into this category should have a three view cervical radiographic series followed by a computer tomography (CT). The indications for imaging are enumerated in the Official Disability Guidelines. Indications include, but are not limited to, chronic neck pain (after three months conservative treatment), radiographs normal neurologic signs or symptoms present; neck pain with radiculopathy if severe or progressive neurologic deficit; etc. 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). The criteria for ordering an MRI of the cervical spine include the emergence of a red flag, physiologic evidence of tissue insult when nerve impairment, failure to progress in a strengthening program intended to avoid surgery and clarification of anatomy prior to surgery. In this case, the injured worker's working diagnoses are cervical spine HNP; cervical spine degenerative disc disease; and cervical spine radiculopathy. MRI dated January 6, 2014 show a signal abnormality in the cervical cord, most pronounced at C7, suggestive of a syrinx. Additional findings included degenerative disc disease with anterolisthesis seem C2 - C3, C3 - C4, C4 - C5 and retrolisthesis C-5 - C6 and C6 - C7. There was a canal stenosis at C4 - C5 mild, C-5 - C6 mild to moderate and C6 - C7 mild canal stenosis. A repeat MRI was performed July 30, 2014. The results show a syrinx cavity lower cervical upper thoracic cord, C7 - C2 measuring 3.6 centimeters cephalocaudad dimension, 3 mm AP dimension. The radiologist recommended MRI thoracic lumbar spine follow-up pre-and post-contrast, MRI cervical spine post-contrast to further assess syrinx cavity. The treatment plan states the treating provider continues to request an updated cervical MRI to monitor the syrinx with the last MRI January 6, 2014. The last MRI according to the documentation is July 30, 2014. After the injured worker is authorized (if authorized) for the ACDF C-5 - C6, a repeat MRI of the cervical spine may be clinically indicated. Authorization for a third MRI of the cervical spine is premature at this time. The MRI cervical spine dated July 30, 2014 states MRI thoracic lumbar spine follow-up for pre and post contrast and MRI cervical spine post contrast is indicated to further assess the syrinx cavity. There is no documentation this follow-up testing has been performed. Consequently, absent documentation for the ACDF C-5 - C6 surgical authorization with no MRI thoracic-lumbar spine follow-up with pre and post contrast and cervical spine post contrast documented to further assess the syrinx cavity (as recommended by the radiologist after the July 2014 repeat MRI cervical spine), repeat MRI cervical spine is not medically necessary.