

Case Number:	CM15-0074686		
Date Assigned:	04/24/2015	Date of Injury:	01/29/2013
Decision Date:	05/22/2015	UR Denial Date:	04/08/2015
Priority:	Standard	Application Received:	04/20/2015

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:

This is a 68 year old female patient, who sustained an industrial injury on January 29, 2013. She reported back, shoulder and arm pain due to a fall. The diagnoses include cervical radiculopathy, myelopathy and degenerative disc disease (DDD), lumbar stenosis radiculopathy and degenerative disc disease (DDD) and right hand Dupuytren contracture. She sustained the injury due to a fall. Per the progress note dated March 5, 2015 she had complains of back pain with right leg numbness and tingling and right upper extremity numbness and tingling; the right hand aching and contracting of hand. It is noted the present symptoms are new. Physical examination revealed use of a cane for ambulation; cervical range of motion- flexion 60, extension 10, left lateral rotation 40 and left lateral bending 45 degrees; cervical tenderness and positive Spurling's on the right with shoulder pain; the right hand- contractures. Lumbar range of motion (ROM) was deferred due to balance and instability; normal gait. The current medications list is not specified in the records provided. She has had cervical MRI on 9/18/2013 which revealed degenerative changes throughout the cervical spine and moderate spinal stenosis at C5-6 level and mild spinal stenosis at C4-5 and C6-7; lumbar MRI on 2/20/2014. She has undergone right shoulder arthroscopic surgery. She was advised to start physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

3D MRI of the cervical spine with and without contrast: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Neck and Upper Back Chapter, MRI Study Indications for Imaging - MRI (magnetic resonance imaging).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Neck & Upper Back (updated 05/12/15) 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." 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." Patient does not have objective evidence of severe or progressive neurologic deficits that are specified in the records provided. She has had MRI cervical spine on 9/18/2013, which revealed degenerative changes throughout the cervical spine and moderate spinal stenosis at C5-6 level and mild spinal stenosis at C4-5 and C6-7. Per ODG neck/ upper back guidelines "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 significant change in signs along with symptoms, since the previous cervical MRI that would require a 3D cervical spine MRI with and without contrast is not specified in the records provided. Rationale for MRI with 3D and contrast is not specified in the records provided. Electrodiagnostic study findings demonstrating objective evidence of neurological deficits in the upper extremities were not specified in the records provided. She was advised to start PT. The response to recent conservative therapy for this injury is not specified in the records provided. Previous conservative therapy notes, (including medication list), are not specified in the records provided. In addition a recent cervical spine X-ray report is also not specified in the records provided. 3D MRI of the cervical spine with and without contrast is not medically necessary for this patient.