MAXIMUS Federal Services

Case Number:	CM15-0096499		
Date Assigned:	05/26/2015	Date of Injury:	06/25/2010
Decision Date:	06/30/2015	UR Denial Date:	04/20/2015
Priority:	Standard	Application Received:	05/19/2015

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: 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 is a 66-year-old male, who sustained an industrial injury on 6/25/2010. He reported neck and back pain after moving equipment, while employed as an information technology analyst. The injured worker was diagnosed as having discogenic cervical radiculopathy, cervical spinal stenosis secondary to repetitive trauma induced degenerative disc and degenerative joint disease, mechanical neck pain syndrome, thoracic outlet syndrome, and cervical spine loss of motion segment integrity/laxity of ligament. Treatment to date has included diagnostics, chiropractic, and medications. On 4/11/2015, the injured worker reported that after previous treatment session, there was a noticeable reduction in cervicothoracic pain and a significant reduction of dullness/numbness over the left lateral torso, right hemi abdomen, and right lower extremity. He demonstrated no spastic or flaccid tone, normal coordination/ proprioception, demonstrated no pathological reflexes, reported normal bowel/bladder function, absent Babinski's response, and had no saddle anesthesia. He had magnetic resonance imaging of the cervical spine (4/10/2015), noting a recommendation for additional evaluation, due to abnormal signal quality in the cervical spinal cord. The completed report was not submitted. Magnetic resonance imaging of the cervical spine with contrast was recommended. Physical exam noted a definite reduction in hypoesthesia over the left lateral chest wall, right hemi torso/abdomen, and right lower extremity. He was scheduled for evaluation by a neurologist on 4/15/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective MRI of the cervical spine (4/11/15): Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), neck and upper back, MRI.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179, 181-183. Decision based on Non-MTUS Citation American College of Radiology (ACR) Appropriateness Criteria https://acsearch.acr.org/docs/69484/Narrative.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses cervical spine MRI magnetic resonance imaging. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints indicates that MRI or CT is recommended to evaluate red-flag diagnoses. MRI or CT is recommended when red flags for fracture, or neurologic deficit associated with acute trauma, tumor, or infection are present. MRI or CT to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure is recommended. Criteria for ordering imaging studies include emergence of a red flag and physiologic evidence of tissue insult or neurologic dysfunction. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electro diagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. An imaging study may be appropriate for a patient whose limitations due to consistent symptoms have persisted for four to six weeks or more to further evaluate the possibility of potentially serious pathology. The neurology consultation report dated 4/14/15 documented right hemihypesthesia, asymmetric deep tendon reflex, and increased muscle tone on the left side with pronator drift. Magnetic resonance imaging MRI of the cervical spine without contrast report dated 4/10/15 noted that the cord demonstrates abnormal signal within the left lateral column at the level of C4-5 and within the left lateral column and centrally at the level of C5 extending to the level of C5-6. The progress report dated 4/11/15 documented that the radiologist recommended additional evaluation of with MRI of the cervical spine with contrast because of abnormal signal quality in the cervical spinal cord. MRI of the cervical spine with contrast was requested. American College of Radiology (ACR) guidelines indicate that MRI with contrast is appropriate for myelopathy. Neurologic abnormalities were noted on physical examination. MRI without contrast demonstrated abnormal signal in the spinal cord. Therefore, the request for MRI with contrast is supported by American College of Radiology (ACR) guidelines. Therefore, the request for MRI of the cervical spine with contrast is medically necessary.