

Case Number:	CM13-0019727		
Date Assigned:	10/11/2013	Date of Injury:	08/01/2013
Decision Date:	01/30/2014	UR Denial Date:	08/22/2013
Priority:	Standard	Application Received:	09/03/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is 74-year-old injured worker who reported an injury on 08/01/2013. Notes indicate that the patient was injured as a result of a fall with the patient hitting the forehead, left wrist, and right elbow. Notes indicate that the patient currently complains of pain to the left side of the head described as a dull pain, which is indicated by the patient as moderately severe. The patient reports having symptoms since 08/01/2013 with the frequency of pain noted as constant. Notes indicate that the patient was initially seen at a hospital emergency room with notes indicating that the patient had undergone CT of the head and neck with no acute issues noted. The patient was seen again on 08/13/2013 with notes indicating no change in the patient's complaints. Notes indicate that the patient was prescribed medication; however, the patient is currently utilizing only over-the-counter acetaminophen indicating that Vicodin is too strong. Objective evaluation of the patient noted that assessment of the cranial nerves was unremarkable as was evaluation of the eyes. Bilateral otoscopic examination of the ears appeared normal with no visual or palpable abnormalities of the patient's mouth or throat. The patient is noted to have normal posture, no facial or head tenderness, and no loss of cervical lordosis. There is no complaint of neck stiffness or splinting with the posterior cervical area non-tender. The patient has evidence of neck muscle tenderness of the trapezius; however, the evaluation of the paracervical and sternocleidomastoid regions was unremarkable. Notes indicate that the patient does have evidence of spasms in the trapezius. Range of motion revealed flexion to 45 degrees, extension 40 degrees, lateral flexion bilaterally at 30 degrees, and lateral rotation of 80 degrees. There was no evidence of muscle weakness in the paracervical musculature.

IMR ISSUES, DECISIONS AND RATIONALES

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

Non contrast CT scan of the neck: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177,179.

Decision rationale: The CA MTUS/ACOEM Guidelines state that criteria for ordering imaging studies are: emergence of a red flag; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery and for clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic 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. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). The documentation submitted for review indicates that this patient has undergone CT of the head and neck in the hospital emergency room at the time of injury. Notes indicate that the findings of the CT were negative. The patient is currently undergoing physical therapy treatment as well as acupuncture therapy, which has been recently certified. However, there remains a lack of objective clinical findings supporting a recommendation for CT. Furthermore, there is a lack of clear clinical rationale for continuing with repeat imaging of the head and neck given that the patient has no demonstrated red flag findings. The request for a non contrast CT scan of the neck is not medically

Non contrast CT Scan of the head: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The California MTUS/ACOEM Guidelines state that criteria for ordering imaging studies are: emergence of a red flag; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery and for clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the

form of definitive neurologic findings on physical examination, electrodiagnostic 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. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). The documentation submitted for review indicates that this patient has undergone CT of the head and neck in the hospital emergency room at the time of injury. Notes indicate that the findings of the CT were negative. The patient is currently undergoing physical therapy treatment as well as acupuncture therapy, which has been recently certified. However, there remains a lack of objective clinical findings supporting a recommendation for CT. Furthermore, there is a lack of clear clinical rationale for continuing with repeat imaging of the head and neck given that the patient has no demonstrated red flag findings. The request for a non contrast CT scan of the head is not medically necessary and appropriate.