

Case Number:	CM13-0036370		
Date Assigned:	12/13/2013	Date of Injury:	10/28/2005
Decision Date:	02/20/2014	UR Denial Date:	09/30/2013
Priority:	Standard	Application Received:	10/21/2013

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 Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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:

The patient is a 57-year-old male who reported an injury on October 28, 2005. The patient is diagnosed as status post anterior C6-7 decompression, fusion, and instrumentation with incomplete consolidation of the allograft. The patient was seen by [REDACTED] on September 12, 2013. The patient was eight (8) months status post C6-7 decompression and fusion. The patient reported intermittent tingling of the radial and dorsal surface of the left forearm and hand. Physical examination revealed decreased sensation in the left C6 dermatome, 5/5 motor strength, decreased cervical range of motion, and 1+ deep tendon reflexes on the left. The x-rays obtained in the office on that date indicated incomplete consolidation of the allograft at C6-7. It is noted that a September 12, 2013 computed tomography (CT) scan also indicated incomplete consolidation of the allograft at C6-7. Treatment recommendations included a 10 to 15 pound lifting restriction and a one (1) year post-operative repeat plain x-ray and CT scan.

IMR ISSUES, DECISIONS AND RATIONALES

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

request for a cervical CT scan to be done in January 2014: 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): s 177-179.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state if physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding the next steps, including the selection of an imaging test to include CT scan for bony structures. The Official Disability Guidelines state indications for CT imaging include suspected cervical spine trauma, known cervical spine trauma with unequivocal plain films, and neurologic deficit. The patient does not appear to meet guideline criteria for a CT scan of the cervical spine. The current CT scan is requested for 1 year post-operative follow-up. However, the future clinical examination and plain x-rays prior to the CT scan would be unknown, making a future CT scan a non-indicated procedure. Based on the clinical information received, the request is noncertified.