

Case Number:	CM14-0007667		
Date Assigned:	02/10/2014	Date of Injury:	03/01/2012
Decision Date:	07/22/2014	UR Denial Date:	12/23/2013
Priority:	Standard	Application Received:	01/21/2014

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. The expert reviewer is Board Certified in Occupational Medicine 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 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/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 is a 42-year-old male patient with a 3/1/12 date of injury. 2/21/14 progress report indicates persistent cervical pain. The patient complains of headache, numbness, and recent weight gain. The physical exam demonstrates cervical tenderness, limited cervical range of motion, positive bilateral Spurling's test, positive Tinel's in the bilateral wrists, diminished sensation in the C5-6 and C6-7 better in the bilateral upper extremities. There is decreased sensation in the digits 1-3. Upper extremity motor exam is unremarkable. 6/3/13 cervical MRI demonstrates, at C3-4, a left paracentral 3-mm disk osteophyte complex which focally indents the ventral thecal sac with minimal flattening of the ventral aspect of the spinal cord on the left. At C5-6, there is a left paracentral 3-mm disk protrusion with left-sided flattening of the spinal cord secondary to overall mild spinal cord compression. 3/6/12 cervical x-rays demonstrate mild degenerative change, loss of cervical lordosis, obscured C7. 5/11/12 cervical MRI demonstrates, at C5-6, a 3-mm left lateral extruded disk herniation with compromise of the ventral left C6 nerve root within the lateral recess. 11/26/13 progress report indicates unchanged cervical pain complaints. The physical exam demonstrates paraspinal muscle tenderness over the cervical spine, guarded cervical range of motion, unremarkable neurologic findings. 12/17/13 progress report indicates cervical paraspinal muscle tenderness, guarded cervical range of motion, unremarkable neurologic findings. An 11/20/13 surgical consultation indicates persistent neck pain radiating to bilateral upper extremities. The physical exam demonstrates cervical tenderness, absent bilateral Hoffmann sign, unremarkable upper extremity neurologic findings. Suggestion was to repeat EMG and nerve conduction test; and a cervical myelogram and contrast CT scan would be reasonable should the patient entertain any surgical option. A 1/9/14 electrodiagnostic testing demonstrates bilateral carpal tunnel syndrome. Treatment to date has included medication, physical therapy, cervical epidural steroid injections, home exercise, wrist splints, and activity

modification. The patient reports that a cervical epidural injection on 7/3/12 did not help very much. The patient was recently approved for carpal tunnel surgery. There is documentation of a previous 12/23/13 adverse determination for lack of planned surgery or need of pre-op imaging.

IMR ISSUES, DECISIONS AND RATIONALES

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

CERVICAL SPINE COMPUTED TOMOGRAPHY AND 3 DIMENSION WITH ANTERIOR -POSTERIOR / LATERAL: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180. Decision based on Non-MTUS Citation Non-MTUS Official Disability Guidelines (ODG) Neck And Upper Back Chapter, CT Myelogram.

Decision rationale: The California MTUS supports imaging studies with red flag conditions; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery; clarification of the anatomy prior to an invasive procedure and definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. The ODG states that cervical CT scans are indicated with suspected or known cervical spine trauma, after obtaining plain films. If there is a contraindication to the magnetic resonance examination such as a cardiac pacemaker or severe claustrophobia, computed tomography myelography, preferably using spiral technology and multi-planar reconstruction is recommended. However, the patient's neurologic findings throughout the entire last year remained unremarkable other than for carpal tunnel syndrome. While carpal tunnel surgery was reportedly authorized, it is unclear what the response was. With several recent cervical MRI scans obtained, a CT scan would not add additional differential diagnostic, especially given the lack of a specific surgical plan. There are no contraindications to MRI, and it is unclear why the imaging studies obtained recently would be insufficient. It is also mentioned that the patient was not considered a surgical candidate. Therefore, the request for cervical spine computed tomography and 3D with anterior-posterior/lateral was not medically necessary.