MAXIMUS Federal Services

Case Number:	CM14-0115625		
Date Assigned:	08/04/2014	Date of Injury:	12/18/2010
Decision Date:	10/02/2014	UR Denial Date:	07/11/2014
Priority:	Standard	Application Received:	07/23/2014

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 Physical Medicine and Rehabilitation 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:

The injured worker is a 36-year-old female who reported an injury on 12/18/2010. The mechanism of injury was the injured worker had a pot filled with other pots that fell and struck her on the back of the head and cervical spine. The diagnostic studies were noted to include an MRI of the cervical spine on 04/01/2014 which revealed a normal appearance of the cervical and visualized upper thoracic vertebrae with a slight curvature, mid cervical spine to the right of midline. There were no significant abnormalities of the cervical or upper thoracic cord. There was no degenerative disc thinning with a mild age related desiccation signal pattern. None of the cervical discs showed any protrusion or significant broad-based disc bulge. At the level of C2-3, there was minimal left foraminal stenosis secondary to a small disc osteophyte complex. At the level of C4-5, C5-6, and C6-T1, there was a mild degenerative disc bulging of 1 to 2 mm only slightly effacing the thecal sac. There is a slight foraminal stenosis at C5-6 that was secondary to uncinate spurs without nerve compromise. The injured worker had electromyography and nerve conduction studies on 05/23/2011, which revealed no abnormalities of the right and lower extremity upper extremities and no evidence of cervical radiculopathy. Other therapies included chiropractic care and a cortisone injection. There were two examinations dated 05/20/2014. The documentation of 05/20/2014 from the Neurologist, revealed the injured worker had numbness and pain in the neck. The injured worker had pain radiating to the right shoulder area. The injured worker's current medications were noted to include Cymbalta 60 mg capsules, tizanidine HCl 4 mg tablets, and Ultracet 37.5/325. The physical examination revealed the injured worker had strength of 5/5 in all extremities. Tone was normal and the right hand was numb and the middle finger was swollen. The diagnosis included cervical neck pain, shoulder pain, and carpal tunnel syndrome. The treatment plan included a continuation of Cymbalta, tizanidine, and Ultracet. The documentation of 05/20/2014 from the neurosurgeon revealed the injured worker

was complaining of paresthesia in the same distribution into the right shoulder and down the right arm, neck pain in his shoulder and down the right arm. The injured worker had right shoulder surgery in 2012. The physical examination revealed the cervical spine was supple with moderately diminished range of motion. There was no nuchal rigidity. There was no spasm. The muscle strength was within normal limits except for pain inhibition of motion of the right shoulder and distal muscle due to inability to stabilize the shoulder girdle. There were no sensory changes. The treatment plan included a CT of the cervical spine to study the bony neural foramen, x-rays of the cervical spine static and dynamic studies, and EMG/NCV of the cervical spine nerve roots involving the right side. There was no Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT Scan of the Cervical Spine: Upheld

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

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

Decision rationale: The American College of Occupational and Environmental Medicine indicates that special studies are not needed unless a 3 or 4 week period of conservative care and observation fails to improve symptoms. The criteria for ordering imaging studies are the emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, a failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to a procedure. Additionally, if physiologic evidence indicates tissue insult or nerve root impairment, there should be the consideration of a possible CT scan for bony structures to further define problem areas. The clinical documentation submitted for review indicated the injured worker had pain in the neck and headaches and had an MRI of the cervical spine that was unremarkable. The documentation indicated there were x-rays of the cervical spine that were ordered to include static and dynamic studies. The studies were ordered at the same time as the CT scan. There was a lack of documentation of an exhaustion and failure of conservative care. Given the above, the request for CT Scan of the Cervical Spine is not medically necessary.