

Case Number:	CM14-0029621		
Date Assigned:	06/20/2014	Date of Injury:	05/10/2011
Decision Date:	07/21/2014	UR Denial Date:	02/13/2014
Priority:	Standard	Application Received:	03/08/2014

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 Internal 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:

Patient is an injured worker with a cervical spine condition. Date of injury was 05-10-2011. The CT C-Spine without contrast 9/2/2013 reported Impression: No evidence of acute fracture of the visualized cervical spine; Degenerative arthrosis most pronounced at the C5-6 level; prevertebral soft tissues are grossly unremarkable. CT Head without Contrast 9/2/2013 reported Impression: No evidence of acute intracranial hemorrhage, midline shift or mass effect. A C- spine MRI performed 08-08-2011 was documented in the Progress note dated 12-27-2013. MRI of the cervical spine 08-08-2011 reported Impression: Intervertebral disc disease and degenerative changes of the cervical spine. Mild grade I retrolisthesis of C5 on C6 measuring approximately 2 mm. Disc bulge osteophyte complexes with associated central subtle annular tears at C5-6 and C6-7. Mild bilateral lateral recess encroachment at C5-6. No significant central canal stenosis at any level. Progress note dated 10-31-2013 documented history of present illness: Injury May 10, 2011, cans of paint hit patient in head, right myofascial pain in neck and right arm and weakness. Progress note 10-31-2013 documented physical examination: cervical spine tenderness; curvature unremarkable; ROM is decreased on flexion, extension and rotation; right arm weakness in strength and diminished strength, grip strength decreased. Progress note dated 12-27-2013 documented history of head injury, myofascial neck and RUE pain and weakness right shoulder arm and fingers. Progress note dated 12-27-2013 documented physical examination: "Motor. symmetric muscle mass, tenderness at a minimum precludes use of right arm in normal fashion." Tremor: none. Assessment: Cervical disc disease, myofascial pain syndrome, pain limb right. Progress note dated 01-06-2014 documented history of "c/o weakness right, chronic problem." Progress note dated 01-06-2014 documented physical examination: neck is supple, cervical tenderness, decreased range of motion and strength in right arm. Utilization

review 02-13-2014 recommended non-certification of the request for CT scan of the cervical spine.

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 without contrast: 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): 177-178.

Decision rationale: Medical treatment utilization schedule (MTUS) American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints addressed imaging studies: MRI or CT to evaluate red-flag diagnoses(D). MRI or CT to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure (D). (D) Panel interpretation of information not meeting inclusion criteria for research-based evidence. CT scan of Cervical spine was performed relatively recently on 9/2/2013. CT Cervical spine 9/2/2013 reported: No evidence of acute fracture of the visualized cervical spine; Degenerative arthrosis most pronounced at the C5-6 level; prevertebral soft tissues are grossly unremarkable. An MRI of the Cervical spine 08-08-2011 reported: Intervertebral disc disease and degenerative changes of the cervical spine. Mild grade I retrolisthesis of C5 on C6 measuring approximately 2 mm. Disc bulge osteophyte complexes with associated central subtle annular tears at C5-6 and C6-7. Mild bilateral lateral recess encroachment at C5-6. No significant central canal stenosis at any level. Progress notes 10-31-2013, 12-27-2013, 01-06-2014 documented chronic neck pain and right upper extremity weakness. No new occupational injuries were documented. Medical records do not provide rationale for an additional CT scan of the cervical spine, given that a CT scan of cervical spine was performed relatively recently on 9/2/2013. Therefore, the request for a CT Scan of the cervical spine without contrast is not medically necessary.