

Case Number:	CM14-0063725		
Date Assigned:	07/11/2014	Date of Injury:	01/23/1997
Decision Date:	09/03/2014	UR Denial Date:	04/14/2014
Priority:	Standard	Application Received:	05/06/2014

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 patient is a 66 year old male with date of injury 1/23/97. The treating physician report dated 4/04/14 indicates that the patient presents with pain affecting his neck, upper back, upper extremities and hip. The patient was working as an electronic technician on 1/23/97. The patient stepped out of an elevator, which was under service. The patient has undergone cervical epidural steroid injections, trigger point injections, intrathecal pump delivery system implantation as well as surgery for L3 burst fracture. He also has had MRIs and x-rays, the latest being 2008. A computed tomography (CT) scan of the lumbar spine was performed on 12/06/11. Current physical examination findings include mildly positive facet loading test on the right for the cervical spine, decreased ranges of motion and a scar on the back that goes from the lumbar spine to the cervical spine. The patient's current diagnoses include chronic pain syndrome, hypertension, cervicalgia, brachial neuritis or radiculitis, lumbago, thoracic or lumbosacral neuritis or radiculitis, a single episode of major depressive disorder, generalized anxiety disorder, pathologic fracture of vertebrae, dietary surveillance and counseling, and obesity. The utilization review report dated 4/13/14 denied the request for CT of the cervical spine based on the rationale of it being recommended that prior to having a CT scan performed a radiographic series should be performed. The patient's last radiographic exam of the cervical spine was performed in 2008. The patient does not have any suspected or known cervical spine trauma that would indicate an immediate need for CT. There are no diagnostic findings or physiologic evidence or neurologic dysfunction.

IMR ISSUES, DECISIONS AND RATIONALES

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

Computed Tomography (CT) cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178 and on the Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper back chapter.

Decision rationale: The patient is a 66 year old male who presents with lumbar pain, which he rates 8-9/10. The current request is for a CT scan of the cervical spine. The patient has undergone epidural injections, intrathecal pump delivery system procedure, surgery for L3 burst fracture, MRIs, x-rays and a previous CT of the lumbar spine. His medications include Hydrocodone-acetaminophen 10/325 mg Q6h max 4/dose for pain, Tizanidine, Flomax, Lisinopril, Xanax and Fluoxetine. The current request is for a CT (computer tomography) of the cervical spine. The ODG Guidelines do not recommend CT scan without first taking cervical radiographs. The patient had an x-ray on October 1, 2008, which showed evidence of fusion at two levels without any instability. There is no mention of evidence of any new trauma. There is no documented x-ray to correlate with the current request for CT scan of the cervical spine. There is no medical rationale provided that indicates a cervical spine trauma has occurred to support a CT scan of the cervical spine. Therefore the request is not medically necessary.