

Case Number:	CM14-0066124		
Date Assigned:	07/11/2014	Date of Injury:	05/11/2000
Decision Date:	08/08/2014	UR Denial Date:	04/24/2014
Priority:	Standard	Application Received:	05/09/2014

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 Neurology 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 (IW) is a 64 Year Old Male with a reported date of injury of 5/11/2000. The mechanism of injury is reported as repetitive use injury. The IW has continued to reported neck pain to his providing physicians. The IW is status post anterior cervical decompression and fusion at C3-C4. A progress note containing an exam noted dated 1/31/14 reports he IW demonstrates bilateral weakness (4/5) strength in shoulder abduction testing, grip strength, and finger abduction. The rest of his upper extremity strength exam is reported as 4+/5. An EMG and Nerve conduction study were also performed on that day report a possible left C5 chronic radiculopathy, however, the report containing the actual needle activity of the EMG is all reported as normal. The IW has had two cervical spine MRI's with one dated 6/12/13 and the other 2/4/14. The results are consistent with both MRI's with post-surgical changes noted at C3-C4 and a grade one retrolisthesis at C4-C5, mild canal stenosis and severe right and mild left neural foramina narrowing. A previous request for a CT of the cervical spine to rule out ossification of the posterior longitudinal ligament was denied.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT of the cervical spine to rule out OPLL (ossification of the posterior longitudinal ligament): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation ODG-Neck & Upper back.

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

Decision rationale: With regards to obtaining imaging of the neck the MTUS has established the following criteria: The emergence of a red flag, physiological evidence of tissue insult or injury, failure to progress in a strengthening program intended to avoid surgery or clarification of anatomy prior to an invasive procedure. In this particular case, the IW (injured worker) has already had a fusion at the C3-C4 level. He did have an EMG and nerve conduction study on 1/31/14 with no abnormality reported with the needle activity but a reported "possible" radiculopathy. There is no evidence the IW is undergoing a strength program with the documentation provided. In addition, the reported neck tenderness or potential ossification of the posterior longitudinal ligament is not designated as a "red flag". The IW most recently had an MRI of the cervical spine on 2/4/14 and his complaint of neck pain has not been reported to have changed in character to warrant additional imaging. The request for a CT of the cervical spine to evaluate for ossification of the posterior longitudinal ligament is not medically necessary.