

Case Number:	CM15-0015823		
Date Assigned:	02/03/2015	Date of Injury:	08/07/2007
Decision Date:	04/13/2015	UR Denial Date:	12/29/2014
Priority:	Standard	Application Received:	01/27/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 60 year old male, who sustained an industrial injury on August 7, 2007. He has reported neck and back injuries from the industrial injury. The diagnoses have included chronic neck pain and C5-5 disc extrusion. Treatment to date has included previous physical therapy and medications. Currently, the injured worker complains of localized low back pain and aching neck pain, which radiates to his shoulders. The injured worker reported that physical therapy has been helpful for the neck and low back. He reported improved range of motion of his shoulders. On examination, the injured worker had less spasm of the upper trapezius than previously. His upper extremity strength was 5/5 and sensation was intact. His lumbar paraspinal muscles were tender to palpation and range of motion was decreased. His lower extremity reflexes were 2+ and his strength was 5/5. On December 29, 2014, Utilization Review non-certified a request for CT myelogram of the cervical spine, noting that in this case there was no mention of any significant neurologic change found in the documentation. The California Medical Treatment Utilization Schedule was cited. On January 27, 2015, the injured worker submitted an application for IMR for review of CT myelogram of the cervical spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Computed Tomography (CT) Myleogram of Cervical Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Part 1: Introduction. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official disability guidelines Neck & Upper Back Chapter, under Computed tomography (CT).

Decision rationale: Based on the 12/12/14 progress report provided by treating physician, the patient presents with neck pain that radiates to the chest, clavicles, shoulders, worse on the left; and has numbness and tingling in the hands, and occasionally shooting pain into the arms. The request is for COMPUTED TOMOGRAPHY (CT) MYELOGRAM OF CERVICAL SPINE. Patient's diagnosis per Request for Authorization form dated 12/19/14 included neck pain. Patient's medications include Aspirin, Ambien, Lithium, Flexeril and Norco. Per treater report dated 12/12/14, "CT of the cervical spine without contrast from 08/20/13 shows mild spurring at C3-C4 with right paracentral disc osteophyte touching the thecal sac with no stenosis. At C5-C6 central disc protrusion, osteophyte complex with calcification effacing the thecal sac. The osteophyte is encraching into the neural foramen causing moderate to severe left and mild-to-moderate right neuroforaminal narrowing. MRI of the Cervical spine from 12/10/13 with impression at C5-C6 a central disc extrusion, 2mm anterior to posterior 5mm left to right disc extrusion, anterior and posterior measurement of spinal canal is 9mm. No cord compression." The patient is retired. ODG, Neck & Upper Back Chapter, under Computed tomography (CT) states, "Not recommended except for indications below. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, and have no neurologic findings, do not need imaging. Patients who do not fall into this category should have a three-view cervical radiographic series followed by computed tomography (CT). In determining whether or not the patient has ligamentous instability, magnetic resonance imaging (MRI) is the procedure of choice, but MRI should be reserved for patients who have clear-cut neurologic findings and those suspected of ligamentous instability." (Anderson, 2000) Indications for imaging CT (computed tomography): Suspected cervical spine trauma, alert, cervical tenderness, paresthesias in hands or feet, Suspected cervical spine trauma, unconscious, Suspected cervical spine trauma, impaired sensorium (including alcohol and/or drugs), Known cervical spine trauma: severe pain, normal plain films, no neurological deficit, Known cervical spine trauma: equivocal or positive plain films, no neurological deficit, Known cervical spine trauma: equivocal or positive plain films with neurological deficit." MTUS/ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12 "Low Back Complaints" under Special Studies and Diagnostic and Treatment Considerations, pg 303-305 states "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option." UR letter dated 12/29/14 states "in this case there is persistent pain, but no mention of any significant neurologic change is noted in the record." Per progress report dated 12/12/14, treater states "the neck pain is getting worse. He is having a lot of palpable spasm. He can get occasional shooting pain into the arms. He has significant spinal stenosis and foraminal stenosis on his CT scan (08/20/13). The patient would like a second opinion surgical consult as his neck pain is getting worse. The previous surgeon suggested cervical surgery and suggested a fusion. Please authorize a spine surgery

consult. Prior to this we need updated studies. The patient gets too claustrophobic for MRIs. He is fine with a CT myelogram." The patient is alert, and presents with cervical tenderness, paresthesias in hands and worsening of symptoms. However, there are no progressive neurologic deficit or significant neurologic findings to warrant an updated imaging. While fusion surgery has been recommended, it is certain that surgery is indicated based on the guidelines. The patient has worsening neck pain without neurologic deficits suggestive of spinal stenosis or myelopathy. The request for an updated CT IS NOT medically necessary.