

Case Number:	CM15-0138314		
Date Assigned:	07/28/2015	Date of Injury:	11/04/2013
Decision Date:	08/31/2015	UR Denial Date:	06/29/2015
Priority:	Standard	Application Received:	07/16/2015

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: Texas, California

Certification(s)/Specialty: Family Practice

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 29 year old female who sustained an industrial injury on November 4, 2013. The mechanism of the injury is unavailable. She has reported pain and stiffness in the lumbar spine and has been diagnosed with right shoulder parascapular strain sprain, cervical spine sprain strain, rule out herniated cervical disc with radiculitis/radiculopathy, mid back strain sprain rule out herniated thoracic disc, and left lateral scoliosis thoracic lumbar spine. Treatment has included medications, physical therapy, acupuncture, chiropractic care, and medical imaging. Examination of the cervical spine revealed flexion at 45 degrees, extension at 55 degrees, rotation at 55 degrees on the right and 40 degrees on the left, and bending to the left was 25 degrees. There was a positive foraminal compression test and positive Spurling's test. There was tenderness noted over the paraspinal musculature with paraspinal spasms. The thoracic spine showed flexion at 40 degrees and rotation was 20 degrees bilaterally. There was focal tenderness detected at cervical and thoracic region. The treatment plan included CT of the thoracic and cervical spine, chiropractic care, acupuncture, and medication. The treatment request included a CT scan of the thoracic spine and CT scan of the cervical spine. The medication list includes Prilosec, Flexeril, Ibuprofen and Xanax. The patient had received an unspecified number of the PT visits for this injury. The patient has had MRI of the cervical spine on 8/25/14 that revealed normal spinal canal and neural foramina. The patient had received an unspecified number of the PT visits for this injury. Any surgical or procedure note related to this injury was not specified in the records provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT scan of thoracic spine: 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: Per the ACOEM chapter 8 guidelines cited below "For most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out". Per the ACOEM chapter 8 guidelines cited below recommend "MRI or CT to evaluate red-flag diagnoses as above, MRI or CT to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. If no improvement after 1 month bone scans if tumor or infection possible, not recommended: Imaging before 4 to 6 weeks in absence of red flags". The patient did not have signs or symptoms of progressive neurological deficits. The patient has had MRI of the cervical spine on 8/25/14 that revealed normal spinal canal and neural foramina. Any plan for neck surgery was not specified in the records provided. The history or physical exam findings did not indicate pathology including cancer, infection, or other red flags. Patient has received an unspecified number of PT visits for this injury. Therefore the request is not medically necessary. The prior PT visit notes were not specified in the records provided. Detailed response to previous conservative therapy was not specified in the records provided. The medical necessity of the request for CT scan of thoracic spine is not fully established in this patient.

CT scan of cervical spine: 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: Per the ACOEM chapter 8 guidelines cited below "For most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out". Per the ACOEM chapter 8 guidelines cited below recommend "MRI or CT to evaluate red-flag diagnoses as above, MRI or CT to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. If no improvement after 1 month bone scans if tumor or infection possible, not recommended: Imaging before 4 to 6 weeks in absence of red flags". The patient did not have signs or symptoms of progressive neurological

deficits. The patient has had MRI of the cervical spine on 8/25/14 that revealed normal spinal canal and neural foramina. Any significant changes in objective physical examination findings since the imaging study that would require a repeat CT scan study were not specified in the records provided. Any plan for neck surgery was not specified in the records provided. The history or physical exam findings did not indicate pathology including cancer, infection, or other red flags. Patient has received an unspecified number of PT visits for this injury. The prior PT visit notes were not specified in the records provided. Detailed response to previous conservative therapy was not specified in the records provided. The request for CT scan of cervical spine is not medically necessary or fully established in this patient.