

Case Number:	CM15-0201589		
Date Assigned:	10/16/2015	Date of Injury:	10/18/2001
Decision Date:	12/03/2015	UR Denial Date:	09/30/2015
Priority:	Standard	Application Received:	10/13/2015

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:

This is a 60 year old female patient, who sustained an industrial injury on 10-18-01. She sustained the injury due to assaulted by a patient. The diagnoses include cervicalgia, cervical radiculopathy, failed neck surgery syndrome, opioid dependence, chronic pain syndrome, and status post C3-4 anterior discectomy and fusion. Per the doctor's note dated 10/7/15, she had pain at 10/10 without medications currently. Per the doctor's note dated 9/2/15, she had complaints of neck and low back pain. The physical examination revealed tenderness to palpation in the cervical paraspinal musculature, upper trapezius muscles, and scapular border, lumbar paraspinal muscles, sacroiliac joint regions; positive Spurling's test, SLR, Patrick's test and facet loading test. Per the doctor's note dated 9-10-15, she had complaints of diffuse body pain and electric-like shocks in her neck, head, arms, and legs. Physical examination findings on 9-10-15 revealed limited cervical range of motion secondary to pain. The medications list includes Lorzone, Cymbalta, Topamax, Suboxone, Dilaudid, Morphine, and Lyrica. She has undergone lumbar ESI on 8/11/2004; lumbar radiofrequency rhizotomy on 9/8/2004; cervical spine fusion surgeries on 1/19/2009 and on 6/25/2014 and lumbar spine fusion surgeries on 8/9/2002 and 9/12/2002. She had multiple diagnostic studies including lumbar discography on 10/14/2004; lumbar spine MRIs; cervical spine CT scan on 7/30/2012, multilevel degenerative disc disease and post operative changes; cervical MRI dated 3/3/15 which revealed fusion of C3-6 without evidence of instability; cervical spine X-rays dated 3/3/15 which revealed well fused cervical construct. Treatment to date has included chiropractic treatment, cervical epidural steroid injections, acupuncture, implantation of an intrathecal pain pump, and medication. On 9-10-15, the treating physician requested authorization for a computed tomography scan of the cervical spine. On 9-30-15 the request was non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT scan of cervical spine qty: 1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Neck & Upper Back (updated 06/25/15), Computed tomography (CT).

Decision rationale: Per the ACOEM chapter 8 guidelines 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. The ACOEM chapter 8 guidelines 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. Patient does not have any evidence of severe or progressive neurologic deficits that are specified in the records provided. She had a cervical spine CT scan on 7/30/2012, multilevel degenerative disc disease and post operative changes; cervical MRI dated 3/3/15 which revealed fusion of C3-6 without evidence of instability; cervical spine X-rays dated 3/3/15 which revealed well fused cervical construct. Per the ODG guidelines Repeat CT is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation where MRI is contraindicated). (Roberts, 2010). Significant change in signs or symptoms since recent cervical diagnostic studies that would require a repeat cervical spine CT scan is not specified in the records provided. Response to recent conservative therapy for this injury is not specified in the records provided. Per the records provided, patient does not have any evidence of red flag signs such as possible fracture, infection, tumor or significant neurocompression. In addition a recent cervical spine X-ray report is also not specified in the records provided. An electro diagnostic study documenting objective evidence of neurological deficit is not specified in the records provided. The medical necessity of CT scan of cervical spine qty: 1 is not established for this patient.