

Case Number:	CM15-0203496		
Date Assigned:	10/20/2015	Date of Injury:	05/18/2001
Decision Date:	12/01/2015	UR Denial Date:	09/15/2015
Priority:	Standard	Application Received:	10/15/2015

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: North Carolina

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 64-year-old, female who sustained a work related injury on 5-18-01. A review of the medical records shows she is being treated for neck pain. In progress notes dated 7-15-15, the injured worker reports chronic, nagging myofascial neck pain and frequent headaches. She reports occasional radiating pain into her right arm. On physical exam dated 7-15-15, she has full strength throughout her arms and her gait is normal. Treatments have included cervical epidural steroid injections-no significant improvements, cervical spine surgery, physical therapy, and medications. The provider reviews the cervical MRI scan dated 6-5-15, which reveals "there are postoperative changes from C4-T1, as expected. None of her preexisting stenosis from C4-7 is present any longer, the spinal canal is capacious, and there are no areas of significant residual foraminal stenosis. At the C3-4 level however, above her fused segments, there is now broad-based ventral disc herniation combined with posterior ligamentous thickening resulting in moderate to severe canal stenosis, but without cord compression. There is no abnormal spinal cord signal." Current medications include-none listed. No notation of working status. The treatment plan includes requests for x-rays and a cervical bone SPECT study. In the Utilization Review dated 9-16-15, the requested treatment of a cervical bone SPECT study is not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical bone SPECT study qty: 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper back: Bone scan.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

Decision rationale: The ACOEM chapter on neck and upper back complaints and special diagnostic studies states: Criteria for ordering imaging studies are: Emergence of a red flag. Physiologic evidence of tissue insult or neurologic dysfunction. Failure to progress in a strengthening program intended to avoid surgery. Clarification of the anatomy prior to an invasive procedure. The provided progress notes fails to show any documentation of indications for imaging studies of the neck as outlined above per the ACOEM. There was no emergence of red flag. The neck pain was characterized as unchanged. The physical exam noted no evidence of new tissue insult or neurologic dysfunction. There is no planned invasive procedure. Therefore, criteria have not been met for imaging of the cervical spine and the request is not medically necessary.