

Case Number:	CM15-0034173		
Date Assigned:	02/27/2015	Date of Injury:	09/15/2000
Decision Date:	04/14/2015	UR Denial Date:	02/10/2015
Priority:	Standard	Application Received:	02/23/2015

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 62-year-old female, who sustained an industrial injury on 9/15/2000. The details of the initial injury were not submitted for this review. The diagnoses have included chronic pain, cervicgia, and radiculopathy after laminectomy/fusion, degenerative disc disease, cervical facet syndrome, and cervical myofascial pain syndrome. She is status post lumbar laminectomy in 2001 and an interbody fusion C5-6 in 2003. Treatment to date has included chronic Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) use, hot and cold pack, walking/home exercise, topical creams, and epidural injections, trigger point injection and joint injections. Currently, the IW complains of persistent left neck pain and recent progressive right hand numbness. The physical examination from 2/4/15 documented decreased cervical and lumbar Range of Motion (ROM). The plan of care included Computed Topography (CT) scan to assess segment degeneration. On 2/10/2015 Utilization Review non-certified a Computed Topography (CT) scan of cervical spine, noting the medical records lacked documentation to support medical necessity. The ACOEM and ODG Guidelines were cited. On 2/23/2015, the injured worker submitted an application for IMR for review of Computed Topography (CT) scan of cervical spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT scan cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 178, Table 8-8, footnote 3; page 304, Table 12-7, footnote 2.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Neck Chapter on Computed Tomography.

Decision rationale: The patient presents with pain and weakness in her neck and upper extremity. The request is for CT scan of the cervical spine. The patient is s/p interbody fusion C5-6 in 2003. The patient has had epidural injections, trigger point injection and medications. The MTUS and ACOEM guidelines do not address this request. However, the ODG guidelines under the Neck Chapter on Computed Tomography states that it is not recommended except for indications below. CT imaging studies are valuable when potentially serious conditions are suspected like tumor, infection, and fracture, or for clarification of anatomy prior to procedure. CT scan has better validity and utility in surgical trauma for high-risk are multiple injured patients. Repeat CT is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. In this case, the patient has had previous CT scans of the cervical spine in 2011 and 2014. The CT scan from 02/21/14 demonstrates mild facet arthropathy at C4-5 and C5-6. The treater requested CT scan of the cervical spine "to assess segment degeneration." The patient does not present with a trauma, new injury and there is no surgical planning to warrant an updated CT scan. The patient complains of worsening neck pain along with some new numbness in the right hand. However, this does not appear to constitute significant change in clinical presentation. No significant progressive neurologic findings are noted. No red flags, no new injuries are noted. The request is not medically necessary.