

Case Number:	CM15-0047355		
Date Assigned:	03/19/2015	Date of Injury:	02/10/1995
Decision Date:	05/01/2015	UR Denial Date:	02/11/2015
Priority:	Standard	Application Received:	03/12/2015

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 56-year-old female who sustained a work related injury February 10, 1995. Past history included cervical radiculopathy, chronic mixed headache syndrome, depression, kyphoscoliosis, s/p T9-S1 posterior fixation, s/p C3-C7 anterior cervical disc fusion. According to an office visit, dated January 28, 2015, a request for a cervical and lumbar CT was made as she continued to have pain and has had past surgical intervention. According to physician's progress notes, dated February 2, 2015, the injured worker presented for follow-up for continued back pain and right greater than left buttock and leg pain. Previous CT findings suggest she has not healed in the cervical spine and that a rod is broken in her lower fusion. A detailed report of previous CT scan was not specified in the records provided Treatment plan included requests for electromyography studies, transforaminal steroid injection L5-S1. The patient's surgical history include lumbar fusion on 10/16/12; revision C3-7 ACDF in May 2014. The patient has had X-ray of the cervical spine that revealed a fractured rod in 8/2014. The patient sustained the injury due to a fall. Patient has received an unspecified number of psychotherapy visits for this injury. The medication list include Baclofen, Dulcolax, Colace, Gabapentin, omeprazole, Miralax, Trazodone, Senna and Methadone. Per the doctor's note dated 3/5/15 physical examination of the cervical spine revealed tenderness on palpation and limited range of motion. The patient has had CT myelogram of the cervical region on 7/31/13 that revealed facet arthropathy and degenerative changes. Patient has received an unspecified number of PT visits for this injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

Computed Tomography (CT) scan of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

Decision rationale: Request: Computed Tomography (CT) scan of the cervical spine. 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 that were specified in the records provided. Per the notes, the previous CT scan findings suggest she has not healed in the cervical spine and that a rod is broken in her lower fusion. The radiology report of the previous CT scan was not specified in the records provided. Any significant changes in objective physical examination findings since the last CT scan that would require a repeat CT scan study were not specified in the records provided. The history or physical exam findings did not indicate additional 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. In addition, it is noted in the records that the patient's pain was relieved with medications and rest. The medical necessity of the request for (a repeat) Computed Tomography (CT) scan of the cervical spine is not fully established in this patient.