

Case Number:	CM15-0231961		
Date Assigned:	12/07/2015	Date of Injury:	02/01/1999
Decision Date:	01/19/2016	UR Denial Date:	11/12/2015
Priority:	Standard	Application Received:	11/25/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 male who sustained an industrial injury February 1, 1999. Past history included left knee surgery 1972, fusion C3-C5 1999, foraminotomy C4-C6 2000, and lumbar fusion L5-S1 2002. Past treatment included medication, acupuncture, heat-ice, massage, home exercise, and TENS (transcutaneous electrical nerve stimulation) unit. Failed treatment included epidural steroid injections and physical therapy. Diagnoses are status post cervical surgery; status post lumbar fusion; lower extremity radiculopathy; failed back syndrome. An initial neurosurgical consultation report dated October 22, 2015, finds the injured worker presenting with complaints of pain in the upper, mid, and low back, radiating down both legs, with numbness tingling and weakness to the lower extremities, and neck pain radiating down both arms, with numbness and tingling in the upper extremities with daily headaches. Physical examination revealed; walks with severe antalgic gait and uses two canes for assistance; cervical spine-tenderness and spasm, decreased sensation C5-C8 dermatomal distributions more on the left; thoracic spine-tenderness with spasm; lumbar spine- tenderness with spasm, straight leg raise positive bilaterally at 20 degrees seated and supine, decreased sensation bilateral L4, L5 and S1 dermatomal distributions, more on the left. Recommendations included MRI's of the cervical and lumbar spines and CT scans of the cervical and lumbar spines. According to a primary treating physician's handwritten progress report dated October 26, 2015, the injured worker presented with complaints of neck and low back pain, and poor sleep. Objective findings included; tenderness and decreased range of motion of the cervical and lumbar spines. No further physician documentation present on examination. Treatment plan included urine toxicology for compliance, pending authorization for a detoxification program, MRI's of the cervical and lumbar spine, CT of the lumbar spine and at issue, a request for authorization dated November 4, 2015, for a CT of the cervical spine. According to utilization review dated November 12, 2015, the request for CT scan for the cervical spine is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT Scan for the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Computed tomography (CT).

Decision rationale: Per the ODG guidelines regarding computed tomography: Not recommended except for indications below. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, and have no neurologic findings, do not need imaging. Patients who do not fall into this category should have a three-view cervical radiographic series followed by computed tomography (CT). In determining whether or not the patient has ligamentous instability, magnetic resonance imaging (MRI) is the procedure of choice, but MRI should be reserved for patients who have clear-cut neurologic findings and those suspected of ligamentous instability. (Anderson, 2000) (ACR, 2002) See also ACR Appropriateness Criteria. MRI or CT imaging studies are valuable when potentially serious conditions are suspected like tumor, infection, and fracture, or for clarification of anatomy prior to surgery. MRI is the test of choice for patients who have had prior back surgery. (Bigos, 1999) (Colorado, 2001) For the evaluation of the patient with chronic neck pain, plain radiographs (3-view: anteroposterior, lateral, open mouth) should be the initial study performed. Patients with normal radiographs and neurologic signs or symptoms should undergo magnetic resonance imaging. If there is a contraindication to the magnetic resonance examination such as a cardiac pacemaker or severe claustrophobia, computed tomography myelography, preferably using spiral technology and multiplanar reconstruction is recommended. (Daffner, 2000) (Bono, 2007) CT scan has better validity and utility in cervical trauma for high-risk or multi-injured patients. (Haldeman, 2008) 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) Indications for imaging -- CT (computed tomography): Suspected cervical spine trauma, alert, cervical tenderness, paresthesias in hands or feet. Suspected cervical spine trauma, unconscious. Suspected cervical spine trauma, impaired sensorium (including alcohol and/or drugs). Known cervical spine trauma: severe pain, normal plain films, no neurological deficit. Known cervical spine trauma: equivocal or positive plain films, no neurological deficit. Known cervical spine trauma: equivocal or positive plain films with neurological deficit. Per the medical records submitted for review, there was no indication that there was a suspected cervical trauma. As the criteria is not met, the request is not medically necessary.