

Case Number:	CM14-0161860		
Date Assigned:	10/07/2014	Date of Injury:	02/24/2004
Decision Date:	10/30/2014	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	10/02/2014

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

There were 72 pages provided for this review. The request for the CT scan of the cervical spine was non certified. There was not progressive neurologic dysfunction. There was an MRI already done on August 22, 2014 which showed relatively severe bilateral foraminal stenosis with a patent central canal at C3-C4, but it does not comment on the status of the fusion at this level. A clinical note from September 15, 2014 states the fusion at C3-C4 is not solid and a CT was suggested. There is however normal motor strength in deep tendon reflexes of the upper extremities. There is decreased sensation in the left hand of all five fingers reported. Records did not reveal with this finding is new. There is no mention of a red flag, or physiologic evidence of neurologic dysfunction not already analyzed by the recent MRI. There is no documentation of failure to progress in the strengthening program. Plain neck radiographs have not been performed to evaluate the fusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 CT scan of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter

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

Decision rationale: The MTUS is silent on cervical CT. The ODG cite the following regarding CT imaging of the cervical spine: 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 In this case, an MRI has already been done which revealed actionable pathology; a CT scan of the same area would be largely redundant, with little clinical gain. The request is not medically necessary.