

<b>Case Number:</b>	CM15-0148873		
<b>Date Assigned:</b>	10/13/2015	<b>Date of Injury:</b>	06/01/2015
<b>Decision Date:</b>	11/30/2015	<b>UR Denial Date:</b>	07/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/31/2015

### 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: Florida

Certification(s)/Specialty: Neurology, 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:

This 38 year old male sustained an industrial injury on 6-1-15. Documentation indicated that the injured worker was receiving treatment for blunt head trauma and concussion without loss of trauma. Previous treatment included physical therapy and medications. In a PR-2 dated 6-12- 15, the injured worker complained of headaches, dizziness and nausea. The injured worker reported having three episodes of nausea since the injury. Objective findings included visual acuity of 20-20, intact cranial nerves, intact sensation and intact strength to bilateral upper and lower extremities. The physician's stated that there were no red flags. The treatment plan included a prescription for Tylenol. In a PR-2 dated 7-2-15, the injured worker complained of worsening headaches associated with neck pain. Physical exam was remarkable for intact cranial nerves, normal eye and ear exam, no tenderness to palpation to the face or head, no loss of cervical lordosis, cervical spine with tenderness to palpation to the paraspinal musculature with spasms in the paracervical and trapezius muscles, "unrestricted" range of motion and intact bilateral upper extremity deep tendon reflexes, sensation and motor strength. The treatment plan included requesting authorization for physical therapy three times a week for two weeks and computed tomography head due to persistent headaches. On 7-16-15, Utilization Review noncertified arthropathy computed tomography scan of the head and neck without contrast.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CT (computed tomography) scan of the head and neck without contrast material:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The medical records provided for review do not support presence of a progressive neurologic decline or myelopathy by reported serial examination. There is no indication in the medical records of suspicion of cancer or infection. ODG guidelines do not support CT scan of cervical spine except in case of new or progressive myelopathy or presence of red flags such as concern for malignancy or infection. In the absence of medical records supporting such findings, CT scan is not supported under ODG guidelines. The request is not medically necessary.