

<b>Case Number:</b>	CM14-0008417		
<b>Date Assigned:</b>	02/12/2014	<b>Date of Injury:</b>	08/27/2010
<b>Decision Date:</b>	06/24/2014	<b>UR Denial Date:</b>	01/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2014

### 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:

This is a 56-year-old male with an 8/27/10 date of injury who slipped between pipes while removing thread protectors for casing. The patient is status post cervical ACDF at C5/6 and C6/7 and a L4/5 and L5/S1 fusion. The patient was seen on 12/5/13 where the patient complained of neck and back pain for which he had already gone to an emergency room and a CT scan had been done. Exam findings revealed decreased sensation in the left C5/6/7/8 and bilateral L5-S1 dermatomes, and 4+ upper extremity weakness, 4+/5 lower extremity weakness. The plan was to obtain the CT's dated 2/1/13 and 12/1/13 at that time. The patient was then seen on 12/13/14 where the CT dated 12/1/13 showed incomplete bone fusion at C6-7, chronic multilevel degenerative disc disease, chronic left C3/4 neural foraminal stenosis, and a 2.5 subluxation of C7 on T1. A posterior fusion at C6/7 was subsequently requested based off the patient's recent CT scan and clinical findings. The UR decision dated 1/7/14 denied the decision given the patient had a recent cervical spine CT, as well as one earlier in the year, and there was no documentation of the former CT results provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CT CERVICAL SPINE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180.

**Decision rationale:** The CA MTUS supports imaging studies with red flag conditions; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery; clarification of the anatomy prior to an invasive procedure and definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. This patient had a recent cervical spine scan on 12/1/13 showing an incomplete fusion at C6/7 noted on a clinic visit date 12/13/14. A posterior fusion was requested from the patient's physician based on this imaging. As a result, there is no necessity for a repeat scan now that the scan results dated 12/1/13 are documented. The request for a CT scan as submitted was not medically necessary.