

<b>Case Number:</b>	CM14-0188018		
<b>Date Assigned:</b>	11/18/2014	<b>Date of Injury:</b>	10/28/2005
<b>Decision Date:</b>	01/06/2015	<b>UR Denial Date:</b>	10/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/11/2014

### 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 Physical Medicine and Rehabilitation 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:

According to the records made available for review, this is a 58-year-old male with a 10/28/05 date of injury, status post C6-C7 decompression, fusion, and instrumentation 18 months ago. At the time (9/15/14) of request for authorization for CT scan 2mm cuts C2 to T1, there is documentation of subjective (intermittent left-sided neck pain with overhead reaching or prolonged extension, and improved tingling and numbness of the upper extremities) and objective (cervical flexion and extension of 45 degrees, cervical rotation of 75 degrees, tenderness over the left cervical suboccipital paravertebral region, decreased biceps reflexes on the right and absent on the left, absent brachioradialis reflexes bilaterally, and decreased triceps reflexes bilaterally) findings, imaging findings (cervical x-rays (9/15/14) report revealed the anterior plate with vertebral body screws remains intact at C6-C7; there appears to be fusion at the disc space and alignment remains anatomic throughout; and postoperative and degenerative changes appear stable), current diagnoses (18 months status post anterior C6-C7 decompression, fusion and instrumentation), and treatment to date (cervical decompression and fusion). Medical report identifies a request for cervical CT scan to document the suspicion of C4 radiculitis secondary to C3-C4 left foraminal stenosis and confirm the suspicion that the interbody fusion at C6-C7 is solid. There is no documentation of a condition/diagnosis (with supportive subjective/objective findings) for which a CT scan of the cervical spine is indicated (equivocal or positive plain films).

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **CT scan 2mm cuts C2 to T1: 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): 177-178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back, Computed tomography (CT)

**Decision rationale:** MTUS reference to ACOEM Guidelines identifies documentation of emergence of red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, or clarification of the anatomy prior to an invasive procedure, as criteria necessary to support the medical necessity of imaging studies. ODG identifies documentation of a condition/diagnosis (with supportive subjective/objective findings) for which a CT scan of the cervical spine is indicated (such as: suspected spine trauma (alert, cervical tenderness, paresthesias in hands or feet; unconscious; or impaired sensorium (including alcohol and/or drugs) and known spine trauma (severe pain, normal plain films, no neurological deficit; equivocal or positive plain films, no neurological deficit; or equivocal or positive plain films with neurological deficit)), as criteria necessary to support the medical necessity of CT scan of the cervical spine. Within the medical information available for review, there is documentation of a diagnosis of 18 months status post anterior C6-C7 decompression, fusion and instrumentation. However, despite documentation of subjective (intermittent left-sided neck pain with overhead reaching or prolonged extension, and improved tingling and numbness of the upper extremities) and objective (cervical flexion and extension of 45 degrees, cervical rotation of 75 degrees, tenderness over the left cervical suboccipital paravertebral region, decreased biceps reflexes on the right and absent on the left, absent brachioradialis reflexes bilaterally, and decreased triceps reflexes bilaterally) findings, and a request for cervical CT scan to document the suspicion of C4 radiculitis secondary to C3-C4 left foraminal stenosis and confirm the suspicion that the interbody fusion at C6-C7 is solid, and given documentation of imaging findings (cervical x-rays identifying the anterior plate with vertebral body screws remains intact at C6-C7; there appears to be fusion at the disc space and alignment remains anatomic throughout; and postoperative and degenerative changes appear stable), there is no documentation of a condition/diagnosis (with supportive subjective/objective findings) for which a CT scan of the cervical spine is indicated (equivocal or positive plain films). Therefore, based on guidelines and a review of the evidence, the request for CT scan 2mm cuts C2 to T1 is not medically necessary.