Case Number:	CM15-0191349		
Date Assigned:	10/05/2015	**Date of Injury:**	01/24/2000
Decision Date:	11/10/2015	**UR Denial Date:**	09/17/2015
Priority:	Standard	**Application Received:**	09/29/2015

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: Montana
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 36 year old female, who sustained an industrial injury on 01-24-2000. A review of the medical records indicates that the injured worker (IW) is undergoing treatment for cervical disc herniation with myelopathy, cervical disc disease, cervical spine strain or sprain, bilateral shoulder adhesive capsulitis, lumbar spine strain or sprain, and thoracic outlet syndrome. Medical records (03-24-2015 to 07-14-2015) indicate ongoing neck pain with progressive onset of numbness and tingling in the left upper extremity. Pain levels were 4 & 9 (at rest & with activity) out of 10 on a visual analog scale (VAS). Records also indicate no changes in activity levels or level of function. Per the treating physician's progress report (PR), the IW has not returned to work. The physical exam, dated 07-14-2015, revealed tenderness, guarding and spasms over the paravertebral region of the cervical spine and bilateral upper trapezius muscles, positive cervical compression test on the left. Slightly decreased muscle strength, restricted range of motion in the cervical spine due to pain and spasms, decreased sensation in the C4 nerve distribution, and decreased sensation in the left upper extremity. Relevant treatments have included: multiple surgeries including a anterior and posterior C3-4 fusion, physical therapy (PT), acupuncture, chiropractic treatments, cortisone injections, epidural steroid injections, work restrictions, and pain medications. No recent x-rays of the cervical spine were noted. The initial request for authorization (07-14-2015) shows that the following test was requested: CT scan of the cervical spine. The original utilization review (09-16-2015) non-certified the request for CT scan of the cervical spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT scan of cervical spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Neck and Upper Back, CT (computed tomography).

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck, computed tomography.

Decision rationale: The MTUS states that for most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red flag conditions are ruled out. Criteria for ordering imaging studies include emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI]for neural or other soft tissue, computed tomography [CT] for bony structures). The ODG guidelines state that cervical computed tomography (CT) is 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 (eg, 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. In this case, the guidelines state that MRI is the study of choice for patients with prior surgery. X-rays should be the initial study performed. No X-ray results are provided. The medical records state that Cervical CT-scan was previously performed. The guidelines state that 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). The request f or CT scan of cervical spine is not consistent with the MTUS and ODG guidelines and is not medically necessary.