

<b>Case Number:</b>	CM14-0180200		
<b>Date Assigned:</b>	11/04/2014	<b>Date of Injury:</b>	01/10/2012
<b>Decision Date:</b>	12/11/2014	<b>UR Denial Date:</b>	10/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/30/2014

### 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 Family 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 50 year old male patient who sustained a work related injury on 1/19/2012. The patient sustained the injury when a metal lid about 100 pound dislocated and fell on him and hit him in the head. The current diagnoses include cervical spondylosis without myelopathy and status post ACF with anterior fixation at C6-7. Per the doctor's note dated 08/05/2014, the patient has complaints of cervical spine pain and headache at 6/10 that was relieved with rest and medication. Physical examination revealed difficulty with extension and mobility with numbness in both arms and hands, flexion 60 degrees, extension 0 degrees, and rotation to the left 30 degrees, motor strength at 4-5/5, negative Spurling test, tenderness on palpation and trigger points, painful range of motion (ROM), normal reflexes and decreased sensation in left thumb. The medication lists include Azithromycin, Bupropion, Hydrocodone 10 Mg-Acetaminophen, Levofloxacin, Methadone, Prednisone, Cymbalta, Wellbutrin, Cyclobenzaprine, Duloxetine, Gabapentin, and Norco. The patient has had cervical spine x-rays on 01/06/2014, that revealed status post ACF with anterior fixation at C6-7 and mild degenerative disc disease. The patient had a CT scan of the cervical spine on 07/18/2013 that revealed some degenerative change at C6-7, no significant stenosis. He has also had an EMG/NCV and a MRI of the cervical spine on 3/1/12 that revealed degenerative changes with disc bulge and foraminal stenosis. The patient's surgical history include anterior cervical discectomy, C6-7 and anterior cervical fusion, C6-7 in June 2012; appendectomy and nasal surgery. The patient has received an unspecified number of physical therapy and aquatic therapy visits for this injury.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **CT scan without contrast of the Cervical Spine: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

**Decision rationale:** Per the ACOEM Chapter 8 guidelines, "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." The ACOEM Chapter 8 guidelines recommend "MRI or CT to evaluate red-flag diagnoses as above, MRI or CT to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. If no improvement after 1 month bone scans if tumor or infection possible, not recommended: Imaging before 4 to 6 weeks in absence of red flags." The patient did not have signs or symptoms of progressive neurological deficits. The patient has had CT scan of the cervical spine on 07/18/2013 that revealed some degenerative change at C6-7, no significant stenosis, anterior cervical discectomy, C6-7; anterior cervical fusion, C6-7 and anterior cervical plate, C6-7. Any significant changes in objective physical examination findings since the last CT scan that would require a repeat CT scan study were not specified in the records provided. Any plan for neck surgery was not specified in the records provided. The history or physical exam findings did not indicate pathology including cancer, infection, or other red flags. The patient has received an unspecified number of physical therapy visits for this injury. The prior physical therapy visit notes were not specified in the records provided. Detailed response to previous conservative therapy was not specified in the records provided. In addition it is noted in the records that the patient's pain was relieved with medications and rest. The medical necessity of the request for CT scan without contrast of the cervical spine is not fully established in this patient. Therefore, this request is not medically necessary.