

<b>Case Number:</b>	CM13-0027203		
<b>Date Assigned:</b>	11/22/2013	<b>Date of Injury:</b>	02/09/2000
<b>Decision Date:</b>	01/30/2014	<b>UR Denial Date:</b>	09/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/20/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in PM&R, has a subspecialty in Interventional Spine 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 physician 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 60 year-old male with history of back and head injury from a work-related MVA on 2/9/00. The 9/13/13 report from ██████ records the chief complaint as altered mental status, fainting, headaches, chest pain, CVA and seizure. The patient was initially being treated for chest pain and a negative cardiac cath. While admitted, he began having weakness and numbness in his upper and lower extremities. ██████ planned to do an emergent laminectomy, but the patient refused until his claim was approval by workers compensation insurance. The 9/11/13 report from ██████ gives the diagnosis of: chest pain; unspecified, intermediate coronary syndrome(HCC), muscle spasm, pseudoseizure, movement disorder, h/o hydrocephalus, leukocytosis The 9/4/13 note from ██████ states the patient was transferred from ██████ for altered level of mentation. He had weakness with difficulty moving all extremities. He was seen and examined at bedside. Patient complained of 7-8/10 right shoulder pain, numbness and tingling on fingers both hands, weakness in upper and lower extremities with the lower extremities progressively worsening over a week. Prior history of brain surgery, knee replacement, and laminectomy, cervical. Exam showed 3/5 motor in deltoid, biceps, triceps, wrist flexors/extensors and all intrinsic hand muscles. Lower extremities 2/5 strength in iliopsoas, quads, hamstrings, anterior tibialis, EHL and gastrocnemius complex. ¾ DTR biceps, triceps patellar and Achilles. Negative Babinski, but positive Hoffman, no clonus. Sensory decreased to light touch, pinprick BLE and BUE. Tender cervical and thoracic paraspinals. IMPRESSION: C3-C6 spinal stenosis, disc herniations, more prominent at C5/6 causing compression on the spinal cord with quadraparesis. Thoracic spinal stenosis at T9/T10 with spinal cord compression and anterior displacement of the spinal cord; bilateral R>L upper and lower extremity radiculopathy, paresis and paresthesia, s/p C6/7 ACDF in 2001. T

## IMR ISSUES, DECISIONS AND RATIONALES

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

**C3-C6 laminectomies, foraminotomies for decompression of the cord and exiting nerve roots:** 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): 791-181.

**Decision rationale:** MTUS/ACOEM guidelines state for surgical considerations there must be "clear clinical imaging, and electrophysiologic evidence, consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short- and long-term." On reviewing the records, there is no electrophysiologic evidence of a cervical root or cord lesion. The 9/1/13 MRI report states that there is no central canal stenosis or foraminal narrowing at C3/4, and reports the spinal cord as normal. The request was for laminectomy and foraminectomy from C3 to C6 is not in accordance with MTUS/ACOEM guidelines.

**C3-C6 posterior fusion with instrumentation for stabilization of the spinal column, autografts and allografts:** 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): 179-181.

**Decision rationale:** MTUS/ACOEM guidelines state for surgical considerations there must be "clear clinical, imaging, and electrophysiologic evidence, consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short- and long-term." On reviewing the records, there is no electrophysiologic evidence of a cervical root or cord lesion. ACOEM states, "The efficacy of cervical fusion for patients with chronic cervical pain without instability has not been demonstrated." The request is for a fusion to stabilize the spinal column, but there is no evidence of instability. There are no flexion/extension studies provided in the medical records provided to IMR. The request is not in accordance with MTUS/ACOEM guidelines.