

Case Number:	CM15-0192701		
Date Assigned:	10/06/2015	Date of Injury:	09/16/2010
Decision Date:	12/01/2015	UR Denial Date:	09/24/2015
Priority:	Standard	Application Received:	09/30/2015

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: Texas, California
 Certification(s)/Specialty: Family Practice

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 50 year old male, who sustained an industrial injury on 9-16-10. The injured worker was diagnosed as having cervical fusion (2000; 2005); lumbar fusion (2010); cervical pain with profound loss of range of motion; C2-3 and C3-4 degenerative spondylosis; history L4-L5-S1 360 degree spinal fusion. Treatment to date has included physical therapy; urine drug screening; medications. Diagnostics studies included MRI 3T - cervical spine (6-30-15); CT cervical spine (7-2-15); MRI lumbar spine (7-2-15). Currently, the PR-2 notes dated 9-15-15 indicated the injured worker presented to this office for a follow-up visit. The provider documents, "He complains that his body is torqued and out of position, and because of his torsion complaints, it is putting stress on his cervical plate." On physical examination, the provider notes "He has a normal bipedal gait, normal erect posture. He has normal fluid motor function for both upper and lower extremities with no long tract signs." The provider reviews standing A-P lateral scoliosis X-rays dated 7-16-15 and reveals, "Well-balanced in the sagittal and coronal plane with a neutral SVA, and pelvic tilt is normal and not consistent with pelvic retroversion." The spinous processes are symmetric at every level in reference to the pedicles showing no evidence of rotation of the torso or the hips. The pelvis, on Scanogram view as well as the AP Scoliosis view, show normal pelvis with no evidence of rotation. A MRI 3T-Cervical spine was done on 6-30-15 with an impression documented as: "There is stable appearance of the C4-C7 intervertebral fusions with anterior fixation hardware at the C6 and C7 levels. Normal alignment and widely patent spinal canal are maintained through the fusion levels. The 2mm diameter bilateral paramedian high signal myelomalacia in the spinal cord at the C5 level on the

T2-weighted images is also unchanged, likely secondary to chronic cord compression preoperatively. Intervertebral disc mild degenerative changes are seen above and below the fusion levels at the C3-C4 and C7-T1 levels with disc osteophyte encroachment on the anterior thecal sac. Mild canal stenosis and mild to moderate neural foramen stenosis are seen at the degenerated disc levels." A CT Cervical Spine without contrast was completed on 7-2-15 was compared to the above MRI with this impression: "There is stable appearance of the C4-C7 intervertebral fusion with anterior fixation hardware at the C8 and 7 levels. No C6-C7 hardware fracture, disconnection, loosening, or backing out are seen. Intervertebral spacers are unchanged at the C4-C5 and C5-C6 levels with bilateral residual vertebral body defects from prior anterior screw fixation. Mature interspace fusions are seen with no signs of pseudoarthrosis. Normal alignment and widely patent spinal canal are maintained through the fusion levels." A MRI of the lumbar spine was also completed on 7-2-15 with an impression of no hardware fracture, disconnection or loosening at fusion levels L4-L5 and L5-S1. There is noted mild to moderate neural foramen stenosis at L2-3, L3-4, L4-5, and L5-S1. The provider is requesting a Neurology Consult at the injured worker's request. The provider notes "He may have issues regarding adjacent level degenerative spondylosis at C3-4 as a source of his neck discomfort, but the hardware is in good position for the cervical and lumbar spine. No evidence of hardware failure. He has loss of normal cervical lordosis of the cervical spine." No surgical indication from the spine standpoint. A PR-2 dated 5-28-15 indicated the injured worker was in the office for an evaluation of his neck and low back pain. He reports he has a cervical fusion in 2000 and then in 2005 and has also had a lumbar fusion in 2010. He complains he feels like he is "twisted" at his torso. His medications are listed as Norco 10-325mg at 4-6 tablets a day, and Ambien and Soma. PR-2 dated 7-2-15 notes same said concerns and examination. The injured worker was involved in a motor vehicle and a bicycle accident indicating he could not check his blind spot on a left turn and a bicyclist ran directly into the driver's side of his car. His concerns prompted the provider to have his driving license pulled at the DMV. A Request for Authorization is dated 9-30-15. A Utilization Review letter is dated 9-24-15 and non-certification for Neurology consultation. A request for authorization has been received for a Neurology consultation. Per the note dated 7/7/15 the patient had complaints of severe neck and knee pain. The patient had difficulty in turning his neck and radiation of pain up to knee. Physical examination of the cervical spine on 5/28/15 revealed positive Hoffman sign and evidence of persistent myelopathy. The patient had positive axial compression test of thoracic and lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurology consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Chapter 7, Independent Medical Examinations and Consultations.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, Independent Medical Examinations and Consultations.

Decision rationale: Per the cited guidelines, "The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise." MRI of the cervical spine revealed stable appearance of the C4-C7 intervertebral fusion with anterior fixation hardware at the C8 and 7 levels. No C6-C7 hardware fracture, disconnection, loosening, or backing out are seen. Intervertebral spacers are unchanged at the C4-C5 and C5-C6 levels with bilateral residual vertebral body defects from prior anterior screw fixation. Mature interspace fusions are seen with no signs of pseudoarthrosis. Normal alignment and widely patent spinal canal are maintained through the fusion levels. Currently, the PR-2 notes dated 9-15-15 on physical examination there was a normal bipedal gait, normal erect posture. He has normal fluid motor function for both upper and lower extremities with no long tract signs. Significant objective functional deficits that would require a Neurology consultation were not specified in the records provided. Presence of significant psychosocial factors was not specified in the records provided. A plan or course of care that may benefit from the Neurology consultation was not specified in the records provided. A detailed rationale for the Neurology consultation was not specified in the records provided. A plan for an invasive procedure was not specified in the records provided. The medical necessity of the request for Neurology consultation is not fully established for this patient. Therefore the request is not medically necessary.