MAXIMUS Federal Services

Case Number:	CM15-0198316		
Date Assigned:	10/13/2015	Date of Injury:	11/17/1999
Decision Date:	11/20/2015	UR Denial Date:	10/05/2015
Priority:	Standard	Application Received:	10/08/2015

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, Florida, California
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:

This injured worker is a 56 year old male who reported an industrial injury on 11-17-1999. His diagnoses, and or impressions, were noted to include: cervical spine injury, sprain with accumulative trauma with cervical myelopathy, spinal cord compression and lower extremity spasticity; lumbar degenerative disc disease and radiculopathy; chronic pain and cervico-occipital headaches; neuralgia; and chronic pain with associated mood disorder. No imaging studies were noted. His treatments were noted to include: an agreed medical examination on 9-27-2000; physical therapy; psychiatric evaluation and treatment; medication management; and modified work duties, though noted taken off work given his significant restrictions. The occupational injury progress notes of 9-16-2015 reported: a transfer of care with new evaluation; progressive upper back-neck pain, with weakness in the legs and hyper-reflexia and persistent pain which resulted in his inability to perform his work; some weakness in the lower extremity; hyper-reflexia and possibly spasticity; that he found his activity tolerance and avoided particularly vigorous, awkward, or forceful activity in order to control his neck pain and hyper-reflexia; that he meditated and did yoga; has shoulder soreness; and increased neck pain with possible dysthymia or hyperthymia. The objective findings were noted to include: slight tenderness over the upper back-neck para-vertebral and upper thoracic muscles, with discomfort in rotating his head from side-to-side; minimal discomfort to the low back; patellar reflexes with suggestion of clonus and involving torso jerk; hyperactive left Achilles reflex; and cervical canal stenosis and spasticity with hyper-reflexia and weakness. The physician's requests for treatment were noted to include: specialized "SSEP" studies to help sort out if the injured worker has spinal

cord damage which was difficult to discern but appeared to be present on clinical exam with subtle radiculopathy; and consultation with a spine surgeon for possible surgical decompression; along with an updated magnetic resonance imaging of the head to evaluate and rule-out Arnold-Chiari malformation, critical to diagnose prior to surgery. The Request for Authorization, dated 9-16-2015, was noted to include: "SSSP's" versus "SSEP" studies, spine surgery consult with a specific doctor; and magnetic resonance imaging of the head. The Utilization Review of 10-5-2015 non-certified the request for: "SSEP" studies; magnetic resonance imaging of the head; and a spine surgeon consultation with a specific doctor.

IMR ISSUES, DECISIONS AND RATIONALES

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

SSEP studies: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC, Neck and upper back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Somatosensory Evoked Potentials: Clinical Applications. E-Medicine. November 19, 2004. Jorge G Burneo, MD, MSPH, Assistant Professor Epilepsy Program, Department of Clinical Neurological Sciences, London Health Sciences Centre, University of Western Ontario, Canada. Coauthored by Gregory Barkley, MD, Director of the Comprehensive Epilepsy Program, Department of Neurology, Case Western Reserve. Lange's: Current Treatment and Diagnostics in Orthopedics, 2002, Skinner et al. Harrison's Principles of Internal Medicine, 2005 Web-based edition.

Decision rationale: This claimant was injured back in 1999. The SSEP was intended to see if there was spinal cord damage. The request was for SSEP vs. SSEP, and there was not a unique specific request. I was not able to find precise opinions on SSEP in either the California MTUS ACOEM or ODG guidelines. There was commentary on surface electromyography, but not on SSEP. Therefore, I searched for other resources. There is an excellent synopsis of the use of this diagnostic tool in E-Medicine.com. It cites that there is a valid use for the test; the exact quotation is: SSEPs are used for clinical diagnosis in patients with neurologic disease and for intraoperative monitoring during surgeries that place parts of the somatosensory pathways at risk. Abnormal SSEPs can result from dysfunction at the level of the peripheral nerve, plexus, spinal root, spinal cord, brain stem, thalamocortical projections, or primary somatosensory cortex. Since individuals have multiple parallel afferent somatosensory pathways (e.g., anterior spinothalamic tract, dorsal column tracts within the spinal cord), recordings of SSEPs can be normal even in patients with significant sensory deficits. Clinical uses of somatosensory evoked potentials include: 1. Evaluation of the peripheral nervous system and the large-fiber sensory tracts in the central nervous system. 2. Localization of the anatomic site of the somatosensory pathway lesions. 3. Identification of impaired conduction caused by axonal loss or demyelination. 4. Confirmation of a nonorganic cause of sensory loss. SEP findings are not disease specific; they can confirm afferent conduction impairment associated with certain disorders. They may be used in the evaluation of the peripheral nervous system when traditional nerve conduction studies are not possible for any reason, or are not reliable due to

technical problems or artifacts. They are rarely used to assess peripheral neuropathy since standard nerve conduction studies are the test of choice. They may be helpful in hereditary neuropathies, such as Charcot-Marie-Tooth disease, Friedreich ataxia, diabetic neuropathy, inflammatory polyradiculopathy such as Guillain-Barr syndrome, infectious causes such as in HIV, or toxic neuropathies. The test of choice in focal neuropathy is standard nerve conduction studies. Entrapment neuropathies such as carpal tunnel syndrome may be found incidentally, when SEPs are recorded. SEPs are useful for the evaluation of brachial plexopathy and traumatic plexopathies. In thoracic outlet syndrome, SEPs are of limited value with regard to the neurogenic variety of plexopathy, and have no established value in the diagnosis of non-neurogenic or vascular variety. Recent studies suggest that SEPs may have some utility in the evaluation of rootlet and root dysfunction. However, needle EMG provides superior information in these orders and remains the test of choice. SEPs may have some utility in the evaluation of acute lumbosacral root disease or in lumbosacral spinal stenosis. No data is available on the role of SEP in the evaluation of thoracic root disease. For Cervical root disease, the EMG is the best neurophysiological tool for the evaluation of this condition. SEPs may or may not have a limited role in these conditions. Finally, they may be used to confirm the presence of normal conduction pathways in patients with conversion disorder, malingering, or other psychological disturbances. Findings must be interpreted carefully, because normal SEP can be seen in patients with "organic" sensory loss. The actual request is not clear, nor is what on physical examination abnormalities would drive the need for this test over others. Insufficient conditions are present to warrant such a test; the request is not medically necessary.

MRI of the head: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Head.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Head, Brain MRI.

Decision rationale: This claimant was injured back in 1999. The intent of the MRI was to rule out Arnold Chiari malformation as a precursor to a surgery to the head. The ODG notes in the head section: Indications for magnetic resonance imaging: To determine neurological deficits not explained by CT; To evaluate prolonged interval of disturbed consciousness; To define evidence of acute changes super-imposed on previous trauma or disease. The request allegedly is as a planning tool for surgery, but the surgical issues are not clear. Also, criteria for an MRI for injury care and assessment are not met to certify the request. The request is not medically necessary.

Spine surgeon consultation: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

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, page 127.

Decision rationale: This claimant was injured back in 1999. It is noted that the spine surgeon consultation was to be with a specific doctor. ACOEM Guidelines, Chapter 7, Page 127, state that 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. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient. An injury surgical lesion is not definitively noted in the records. The rationale for specialist referral, therefore, is unclear. This request for the consult fails to specify the concerns to be addressed in the independent or expert assessment, including the relevant medical and non-medical issues, diagnosis, causal relationship, prognosis, temporary or permanent impairment, work capability, clinical management, and treatment options. At present, the request is not medically necessary.