MAXIMUS Federal Services

Case Number:	CM15-0212290		
Date Assigned:	11/02/2015	Date of Injury:	03/10/2007
Decision Date:	12/14/2015	UR Denial Date:	10/08/2015
Priority:	Standard	Application Received:	10/28/2015

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: Illinois, California, Texas
Certification(s)/Specialty: Orthopedic Surgery

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 47-year-old male who sustained an industrial injury on 3/10/07, relative to a motor vehicle accident. He underwent a C5/6 anterior cervical discectomy and fusion (ACDF) in 2007 and a C6/7 ACDF in 2010. Past medical history was positive for multiple sclerosis. The 8/25/15 spine surgery comprehensive re-evaluation form cited complaints of neck and arm pain, back and leg pain. He complained of constant grade 6/10 neck pain and 5/10 arm pain with some burning pain in the anterior chest. His condition was complicated by multiple sclerosis but this was in a fairly good form of remission or at least quite stable. Physical exam documented limited and painful range of motion with only about 25% of flexion and extension. He had 4/5 global upper extremity weakness, moderate grip strength weakness, absent upper extremity deep tendon reflexes, negative Hoffman's bilaterally. The 5/19/14 MRI showed a small lesion behind the body of C4 within the spinal cord itself that appeared to be ischemic. The radiologist felt it had been stable since 2012. There was an annular bulge at C6/7 with approximately 50% loss of disc space height at that level. There was some impingement against the thecal sac and spinal cord, but the spinal cord was not deformed. There was cerebrospinal fluid around the spinal cord laterally and posteriorly. The C7/T1 neural foramen appeared normal in dimensions. At C4/5, there was severe foraminal stenosis. At C3/4, there was moderate foraminal stenosis. The CT scan on 8/12/14 confirmed solid arthrodesis at C5/6 and C6/7 and confirmed the findings of severe C4/5 and moderate C3/4 foraminal stenosis. The 8/25/15 cervical spine x-rays showed arthrodesis at C5/6 and C6/7 with a plate at C6/7. There was no instability or anterolisthesis of C7 on T1 with flexion. There was 50% loss of disc space height at

C7/T1, and the disc spaces at C3/4 and C4/5 appeared normal. There were osteophytes adjacent to the C4/5 disc space. The neurosurgeon did not recommend surgery at C7/T1 as there was no instability, mild spinal stenosis and no foraminal stenosis. The injured worker complained of weakness occurring with swimming from his shoulder to the tips of the fingers. The neurosurgeon felt these symptoms should not occur simply from the annular bulging at C7/T1 and were a combination of foraminal stenosis that was present at C3/4, C4/5 and the central stenosis at C7/T1. He did not have abnormal upper extremity reflexes, they are all absent. There was no Hoffman's. He had ischemia in the spinal cord representing myelomalacia which was stable and could certainly contribute to his feelings of weakness. However, surgery at C7/T1 would not relieve all his symptoms. The 9/25/15 treating physician report indicated the injured worker was felt to be deteriorating. He had been evaluated at another facility and was not thought to be a surgical candidate. The injured worker was requesting a second opinion. Authorization was requested for two neurological surgery consultations for the cervical spine. The 10/8/15 utilization review non-certified the request for two neurological surgery consultations for the cervical spine as there was no documentation of any significant change in neurological status or new focal neurologic deficit for which a 2nd opinion neurologic consultation would be medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

2 neurological surgery consults for the cervical spine: Overturned

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, page 127.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and Consultations, page(s) 127.

Decision rationale: The California MTUS guidelines state that referral for surgical consultation is indicated for patients who have persistent, severe, and disabling shoulder or arm symptoms, with activity limitation for more than one month or with extreme progression of symptoms, and unresolved radicular symptoms after receiving conservative treatment. Guidelines typically require 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. The ACOEM guidelines support referral to a specialist 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. Guideline criteria have been met. This injured worker presents with function-limiting neck and upper extremity pain and weakness that is reported worsening. Past medical history is significant for multiple sclerosis and multilevel cervical fusion. Clinical exam findings are consistent with imaging evidence of multilevel stenosis and myelomalacia. Evidence of long-term reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. It seems reasonable to allow a second neurosurgical opinion given the complexities of this case. Therefore, this request is medically necessary.