

Case Number:	CM13-0015414		
Date Assigned:	11/06/2013	Date of Injury:	07/13/2012
Decision Date:	02/11/2014	UR Denial Date:	07/24/2013
Priority:	Standard	Application Received:	08/22/2013

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 Internal 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 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:

The injured worker suffered an initial low back injury in June 2012. He reported a second accident in July with low back and shoulder pain, both with radicular features. Diagnosis was lumbar strain with radiculopathy and shoulder strain. A new claim was started. He was treated conservatively with tramadol, capsaicin, Naprosyn, oral Solu-Medrol and later Tylenol with codeine. He received cortisone injections into shoulder and leg when radicular pain persisted, one Toradol injection and physical therapy. MRI attempts failed because of fear of noise. Sedation was planned, but the worker feared anesthesia due to a history of heart disease. Scheduling with him was also difficult. An MRI of the spine with sedation was accomplished in September and showed multilevel degenerative disease, severe L4-5 canal stenosis and compression of the thecal sac. An MRI of the shoulder showed severe rotator cuff tendinopathy without well-defined full-thickness tear and impingement syndrome. He was referred to Orthopedics for further management. Medicines were Naprosyn and omeprazole. He returned to light duty (no reaching) and physical therapy after two weeks. His shoulder was injected, and in November he received an epidural steroid injection (ESI). He missed three of his last five therapy appointments and declined to continue in November. Shoulder surgery was planned in March, but the patient had had a myocardial infarction in December 2012, had reversible ischemia on stress echo and was not cleared by Cardiology. In April the worker was placed back on total disability and Pain consultation for two ESIs was requested. He was seen by [REDACTED] in June, who recommended bilateral L4 facet blocks and a lumbar root block. The injured worker has requested a second opinion based on his dissatisfaction with the Pain physician appointment.

IMR ISSUES, DECISIONS AND RATIONALES

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

consultation with a Pain Management Specialist: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 250. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Decision rationale: The MTUS does not directly address the right to a second opinion. Page 250 of the ACOEM states that "The clinician should discuss the uses and yields of the content, effects, mechanics and effectiveness of proposed treatment methods" and adds, "An apprehensive patient requires more detailed information and discussion." This was an apprehensive patient, as shown by his reluctance to undergo an MRI, or sedation. The visit requested was not for just an additional visit, but for a second opinion regarding recommendation for an invasive procedure. Thus rather than simply a matter of personal preference it can be seen as a request for the right to understand, choose and accept treatment options, by a worker who has shown a pattern of initial apprehension about accepting recommended procedures. The ODG guidelines state that office visits are recommended as determined to be medically necessary. Therefore this request is medically necessary.