

Case Number:	CM13-0022275		
Date Assigned:	11/13/2013	Date of Injury:	02/05/2010
Decision Date:	10/16/2014	UR Denial Date:	08/26/2013
Priority:	Standard	Application Received:	09/10/2013

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. The expert 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 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/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 patient is an injured worker with the diagnosis of cervical disc herniation with radiculopathy. Date of injury was 02-05-2010. Mechanism of injury was a fall. Pain management consultation report dated March 16, 2012 provided a case summary. The patient's chief complaint was bilateral neck pain radiating down the left upper extremity and lower back pain radiating down the left lower extremity, and diffuse pain and spasm throughout the entire back region. These pains began on February 6, 2010 at which time she was at work and fell. Past medical history included high blood pressure, mitral valve prolapse, depression, and anxiety. Past surgical history included right carpal tunnel syndrome with right ulnar nerve release and right thumb release in 2003. Medications included Motrin, Verapamil, Lexapro, Topamax, and Soma. Past treatments included acupuncture, chiropractic manipulation, physical therapy, and TENS unit. MRI of cervical spine demonstrated degenerative vertebral change and disc disease of the mid-cervical spine with mild to moderate central stenosis at C5-6, and mild central stenosis at the C6-7 level. There was a central osteophyte protrusion complex and left posterior protrusion contributing to this at C5-6 level and causes severe left lateral recess narrowing. There is likely compression of the left C6 root and left lateral recess. There are also degenerative changes causing moderate and severe left foraminal narrowing at this level. Diagnoses included degenerative disc disease with left cervical radiculopathy, myofascial pain of the neck, left shoulder pain, and left lumbosacral radiculopathy. Epidural steroid injection 3rd ESI was approved on 10/23/13. Primary treating physician (neurology) report dated 09-24-13 documented subjective complaints of headaches, neck pain in the upper back pain in the left shoulder and pain in the lower back with depression, anxiety and insomnia. The patient has not been seen by the neurosurgeon for her cervical disc herniation. The patient said on 9/2/13 she woke up with severe neck pain going down to the right scapula and right upper arm. The pain

was so severe to the point she could not move her right arm. The patient tried to use an arm sling and deal with the pain by her self. She could not bear the pain any more. Therefore she went to the ER emergency room the same night of 9-2-13. She said that the MRI of the neck was done. The ER doctor referred her to a neurosurgeon to consider surgery of her cervical spine. The treating physician recommended that the patient should be seen by a spine surgeon in the specialty of neurosurgery to consider surgical intervention of her non resolving neck pain and pain down to the right arm from the cervical disc herniation. Physical examination was documented. The neck showed decreased range of motion in lateral bending, and rotation to the right and flexion forward. The patient has radicular pain down to the right shoulder, right upper arm. The muscle bulk, tone, and strength were normal in both upper extremities. The sensory exam showed decreased pinprick, and light touch of the right forearm on the radial aspect. The lower back showed full range of motion. The straight leg raising was negative at 90 degree bilaterally. Diagnoses were post traumatic headaches, cervical disc herniation with radiculopathy down to the right arm, status post left shoulder arthroscopic repair, adjustment disorder with depression, anxiety and insomnia. Treatment plan included cervical epidural block. The treating physician recommended that patient should be seen by the neurosurgeon to evaluate for her cervical spine injury and possible cervical spine surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

NEUROSURGEON CONSULT: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: , , 127

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 75. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 7 Independent Medical Examiner Page 127

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses occupational physicians and other health professionals. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 5 Cornerstones of Disability Prevention and Management (Page 75) states that occupational physicians and other health professionals who treat work-related injuries and illness can make an important contribution to the appropriate management of work-related symptoms, illnesses, or injuries by managing disability and time lost from work as well as medical care. ACOEM Chapter 7 Independent Medical Examiner (Page 127) states that the health practitioner may refer to other specialists 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, or fitness for return to work. A consultant may act in an advisory capacity, or may take full responsibility for investigation and treatment of a patient. Primary treating physician (neurology) report dated 09-24-13 documented the diagnosis of cervical disc herniation with radiculopathy down to the right arm. The treating physician, who is a neurologist, recommended that the patient should be seen by a spine surgeon in the specialty

of neurosurgery to consider surgical intervention of her neck pain and pain down to the right arm from the cervical disc herniation. Past treatments included acupuncture, chiropractic manipulation, physical therapy, TENS unit, medications, and epidural steroid injections. MRI of the cervical spine demonstrated degenerative vertebral change and disc disease of the mid-cervical spine with mild to moderate central stenosis at C5-6, and mild central stenosis at the C6-7 level. There was a central osteophyte protrusion complex and left posterior protrusion contributing to this at C5-6 level and caused severe left lateral recess narrowing. There was likely compression of the left C6 root and left lateral recess. There were degenerative changes causing moderate and severe left foraminal narrowing at this level. The treating physician (neurologist) recommended that patient should be seen by the neurosurgeon to evaluate for her cervical spine injury and possible cervical spine surgery. Medical records indicate significant cervical spine pathology that would benefit from the expertise of a neurosurgeon. The request for a consultation with a neurosurgeon is supported by medical records and MTUS and ACOEM guidelines. Therefore, the request for neurosurgeon consult is medically necessary.