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| Case Number: | CM13-0035939 | | |
| Date Assigned: | 12/13/2013 | Date of Injury: | 10/27/2011 |
| Decision Date: | 04/14/2014 | UR Denial Date: | 09/19/2013 |
| Priority: | Standard | Application Received: | 10/18/2013 |

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 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 a 31 year old female who was injured on 10/27/2011. Mechanism of injury is unknown. Per the records, he carries a diagnosis of hypertension, sleep disorder, cervical disc protrusion, cervical sprain, cervical radiculopathy, lumbar radiculopathy and lumbar muscle spasm. Prior treatment history has included physical therapy and TENS treatment. She also had acupuncture to the knee and utilizes ibuprofen. On 02/15/2013 patient underwent left L5 selective nerve root block under fluoroscopic guidance. Diagnostic studies reviewed include MRI of the lumbar spine dated 09/26/2013 with the following conclusion: 1) L4-5: 1-2 mm posterior disc bulge without evidence of canal stenosis or neural foraminal narrowing. 2) L5-S1: Posterior annular tear. 3-4 mm posterior disc bulge resulting in mild to moderate right and mild Final Determination Letter for IMR Case Number [REDACTED] left neural foraminal narrowing in conjunction with facet joint hypertrophy. Bilateral exiting nerve root compromise is seen. MRI of the cervical spine dated 09/26/2013 with the following conclusion: 1) Spondylotic change, as described. 2) C2-3: 2-3 mm posterior disc bulge resulting in moderate right neural foraminal narrowing in conjunction with uncovertebral osteophyte formation. Right exiting nerve root compromise is seen. 3) C3-4: 2-3 mm posterior disc bulge resulting in mild bilateral neural foraminal narrowing. The central canal is adequately patent. Bilateral exiting nerve root compromise is seen. 4) C4-5: 2-3 mm posterior disc bulge resulting in moderate right and mild left neural foraminal narrowing intrauterine. Bilateral exiting nerve root compromise is seen. 5) C5-6: 2-3 mm posterior disc bulge resulting in moderate neural foraminal narrowing in conjunction with uncovertebral osteophyte formation. Right exiting nerve root compromise is seen. 6) C6-7: 1-2 mm posterior disc bulge without evidence of canal stenosis or neural foraminal narrowing. An MRI of the left foot dated 09/25/2013 was reported as unremarkable.

IMR ISSUES, DECISIONS AND RATIONALES

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

INTERNAL MEDICINE CONSULTATION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation California ACOEM Guidelines, Chapter 7, page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation California ACOEM Guidelines, Chapter 7, page 127.

Decision rationale: Per the guidelines, a practitioner can refer to other specialists if the diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the course of plan of care would benefit from additional expertise. The documents provided do not discuss why an Internal Medicine consult is being requested. While the patient has a diagnosis of hypertension and sleep disturbance per the records, there is no discussion regarding how well these conditions are controlled or if the patient is undergoing any therapy. The patient's chart does not list any conditions that are under diagnostic uncertainty or that would benefit from additional Internal Medicine expertise. Thus, the request for Internal Medicine consultation is not warranted.