MAXIMUS Federal Services

Case Number:	CM13-0044869		
Date Assigned:	12/27/2013	Date of Injury:	11/05/2012
Decision Date:	02/24/2014	UR Denial Date:	10/17/2013
Priority:	Standard	Application Received:	10/29/2013

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 Pain Management, has a subspecialty in Disabilty Evaluation, 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:

As per medical records reviewed, the claimant is a 47-year-old who was injured on 11/05/12. The claimant reports ongoing midline posterior neck pain. The claimant notes right tinnitus and difficulty remembering since the accident. The claimant notes headaches. The claimant also reports left shoulder pain when flexing the right shoulder forward. The claimant presents with depression, anxiety, and difficulty sleeping. On exam, the cervical spine shows tenderness and muscle spasms in the paraspinal muscles bilaterally. Range of motion in the cervical spine is limited in all planes. There is tenderness in the trapeziuo. There is decreased sensation in the left upper extremity. The left shoulder shows decreased range of motion due to pain. Muscle strength in the left shoulder is graded 5/5. There is tenderness in the acromioclavicular joint and subacromial space. There is positive Impingement sign and Hawkin's sign. Magnetic resonance imaging (MRI) of the cervical spine without contrast dated 01/08/13 reveals moderate posterior disc osteophyte complex at C5-C6 which leads to moderate to severe central stenosis with little Cerebrospinal fluid (CSF) surrounding the cord and flanening of the anterior margin of the cord. There is also uncovertebral hypertrophy which leads to severe right and moderate to severe left forarninal stenosis. At C6-C7, there is a small posterior disc osteophyte complex which leads to rnild to moderate central stenosis as well as mild narrow1ng of the foramina. At C4-C5, there is severe left facet degeneration leading to minimal anterolisthesis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Eye doctor referral: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 22, 127.

Decision rationale: The CA MTUS/ACOEM guidelines under the section General Approach to Initial Assessment and Documentation states: A focused medical history, work history, and physical examination generally are sufficient to assess the patient who complains of an apparently job-related disorder. However, in this patient, the treating provider stated that patient has a complaint of blurry vision and watery eyes, but failed to document any objective findings for the eye examination. For instance, in the medical record dated 12/09/2013 stated on Head/Ear/Eye/Nose/Throat (HEENT):decreased hearing right ear, with no documentation of eye examination findings and there is no eye related diagnosis listed in the assessment section of the medical record. According to the ACOEM guidelines, "the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex (In this case, there is no diagnosis), when psychosocial facts are present, or when the plan or course of care may benefit from additional expertise. An independent medical assessment may also be useful in avoiding potential conflict(s) of interest when analyzing causation or when prognosis, degree of impairment, or work capacity requires clarification. A referral may be for. (1) 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. In this particular patient, it is unclear why a referral to eye specialist is required, hence the referral for eye doctor is not medically necessary.

Cervical epidural steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 300,Chronic Pain Treatment Guidelines Section Epidural Steriod Injection, pg. 46 Page(s): 46.

Decision rationale: The CA-MTUS indicates that "the purpose of Epidural Steroid Injections (ESI) is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit". Occupational Medicine Treatment Guidelines stated "Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long term functional benefit, nor does it reduce the need for surgery. One of the criteria for epidural steroid injection stipulates that Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. However, the EMG (Electromyography)/NCS (Nerve

conduction studies)study performed on 08/26/2013 reported "No significant abnormalities were noted in the above studies which probably exclude the possible nerve entrapment syndrome neuropathy, cervical radiculopathy and thoracic outlet pathology. The EMG is clinically indicated based on patient complain of pain radiation to the neck". While it is noted in this case that the claimant has ongoing complaints in the cervical spine with decreased sensation in the left upper extremity noted, distribution of which is not specified to correlate with imaging or EMG/NCS. Also in the medical record dated 9/12/2013 it stated: In regards to the cervical spine, the patient had a previous magnetic resonance imaging (MRl) done in January of 2013. Impressions of that imaging study included moderate posterior disc osteophyte complex at CS-6, leading to moderate to severe central stenosis, with flattening of the anterior margin of the cord. Uncovertebral hypertrophy resulted in severe right and moderato to severe left foramina! stenosis. At C6-7 there was a posterior disc osteophyte complex leading to mild to moderate central stenosis. The foramina were mildly narrowed. Generally there was a straightening of the normal cervical lordosis. It was also noted that there was severe left facet degeneration at C4-S, leading to minimal anterolisthesis, which caused mild to moderate left foramina! Stenosis. However, the electrodiagnostic studies did not find any evidence of nerve impingement, therefore the request for Cervical Spinal epidural steriod injection is not medically necessary.