

Case Number:	CM14-0002497		
Date Assigned:	01/24/2014	Date of Injury:	09/18/2012
Decision Date:	06/20/2014	UR Denial Date:	12/24/2013
Priority:	Standard	Application Received:	01/07/2014

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 Physical Medicine & Rehabilitation 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 injured worker reported an injury on 09/18/2012. The mechanism of injury was a lifting injury. An MRI of the thoracic spine dated 03/06/2013 stated that the injured worker had abnormal signal changes and endplate concavities at L1-2 incompletely seen because the observations were at the bottom of several sagittal images and a 6 mm L1-2 endplate ridge protruding into the central canal. The MRI of the cervical spine dated 03/08/2013 showed: straightening of the normal cervical lordotic curvature, multilevel loss of disc space signal, multiple stenotic foramina best visualized on selected key axial images with very high grade right C3-4 foraminal stenosis; C4-5 had a 3 mm disc bulge or disc herniation; C5-6 and C6-7 have loss of disc space height with a 2 mm endplate ridge indenting the cal sac at C6-7. MRI of the lumbar spine dated 03/27/2013 revealed multilevel loss of disc space signal with loss of disc height at L4-5 and L5-S1; multiple disc abnormalities as measured per T2 sagittal image, concerned raised for L1-2 disc space with an inferior L1 endplate and a superior L2 endplate concavity also at the inferior L1 endplate missing, diffuse bone bruise edema changes throughout all of L2 and most of L1, contrast enhancement of tissue within both of the opposing endplate concavities as well within the disc space itself, a destructive bony process of this sort of enhancement could be due to a disc space infection or neoplasm. An electromyogram completed on 04/12/2013 showed a normal EMG of both lower extremities. Per the progress note dated 07/18/2013, the injured worker had been hospitalized in June 2013 and was found to have osteomyelitis. The injured worker underwent drainage of the abscess and was prescribed antibiotics for 6 weeks. The aspirates of that osteomyelitis were all negative for bacteria, fungus, and AFB. The injured worker saw an infectious disease physician once in 07/2013 and again on 10/22/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

SECOND OPINION CONSULTATION WITH AN INFECTIOUS DISEASE

SPECIALIST: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS ACOEM, Foundation Chapter: Independent Medical Examinations and Consultants, 2011, Chapter 6 and the Non-MTUS Official Disability Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ACOEM, CA guidelines premium, Independent medical examinations and consultations, pg 127

Decision rationale: ACOEM guidelines state that the occupational health practitioner may refer to other specialists 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 to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability and permanent residual loss or fitness to return to work. Per the provided documentation, the injured worker had already seen an infectious disease doctor twice, once in 07/2013, once in 10/2013, when she was hospitalized with the osteomyelitis. There was no indication of bacteria, fungi, or AFB in the fluid that was extracted. The requesting physician's rationale for the request was unclear. The injured worker had antibiotic treatment for 6 weeks and is no longer having symptoms. Therefore, the request for a second opinion consult with infectious disease specialist is not medically necessary and appropriate.