MAXIMUS Federal Services

Case Number:	CM14-0077528		
Date Assigned:	07/18/2014	Date of Injury:	02/01/2012
Decision Date:	08/25/2014	UR Denial Date:	05/09/2014
Priority:	Standard	Application Received:	05/27/2014

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 Orthopedic Surgery and is licensed to practice in Texas, Montana, and Tennessee. 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 is a 57-year-old male who reported an injury on 02/01/2012. The mechanism of injury was not provided. Prior and current treatments included physical therapy. The mechanism of injury was cumulative trauma. The injured worker was noted to have undergone x-rays. The injured worker underwent an MRI of the cervical spine on 08/06/2013. Findings per the physician documentation were that the injured worker had moderate cervical degenerative changes with mild to moderate spinal canal stenosis and mild to moderate cord effacement at C5-6 and mild spinal canal stenosis with mild cord effacement at C4-5 and C3-4. There were chronic degenerative changes as well as possible foraminal disc protrusion causing high grade foraminal stenosis on the right at C3-4. There was milder foraminal stenosis at other levels. Compared to 04/06/2012, there was a mild worsening of degenerative changes at C3-4 where there was new minimal anterolisthesis with increased spinal canal stenosis, and to a lesser extent at C5-6 where foraminal stenosis had mildly worsened. There was a new small superior endplate Schmorl's node at C7 with associated bone marrow edema suggesting an acute subacute Schmorl's node potentially associated with the neck pain. The documentation of 03/19/2014 revealed the injured worker had complaints of constant mild to moderate with frequent moderate to severe burning pain in the neck. The injured worker was noted to have radiating pain and weakness to the bilateral upper extremities, left worse than right. Prior treatments included short acting narcotics and a radiofrequency ablation as well as physical therapy. The physical examination revealed muscle tightness over the bilateral paracervical muscles and the Spurling's test was positive bilaterally. There were no overt upper extremity strength deficits on the examination.

IMR ISSUES, DECISIONS AND RATIONALES

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

3 Visits with Spine Surgeon, Consultation and Treatment.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 166,180.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180.

Decision rationale: The ACOEM Guidelines indicate a surgical consultation may be appropriate for injured workers who have persistent severe and disabling shoulder or arm symptoms, with activity limitation for more than 1 month, or with extreme progression of symptoms. There should be documentation of clear clinical, imaging, and electrophysiological evidence consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short and long-term. There should be documentation of unresolved radicular symptoms after receiving conservative treatment. The clinical documentation submitted for review indicated the injured worker had clear clinical evidence. The MRI that was submitted for review was incomplete. As such, there was no documentation of findings to support radiculopathy. There was no electrophysiological evidence submitted for review. The request for 3 visits with a spine surgeon including consultation and treatment would not be appropriate as the decision for treatment would be decided upon consultation. The injured worker was continuing to utilize physical therapy. Therefore, there was a lack of documentation to support a failure of conservative care. Given the above and that there was a lack of documentation of clear imaging and electrophysiological evidence of a lesion, the request for 3 Visits with Spine Surgeon, Consultation and Treatment is not medically necessary.