

<b>Case Number:</b>	CM14-0188129		
<b>Date Assigned:</b>	11/18/2014	<b>Date of Injury:</b>	09/25/1997
<b>Decision Date:</b>	01/07/2015	<b>UR Denial Date:</b>	10/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/12/2014

### 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 Family Medicine and is licensed to practice in New Jersey. 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 worker is a 63 year old female who was injured on 9/25/1997. She was diagnosed with cervicalgia, degenerative cervical disc disease, occipital neuralgia, shoulder pain/impingement syndrome, shoulder sprain/strain, and later chronic pain syndrome. She was treated with medications and median nerve branch block. The only progress note provided for review was from after the request, and was from 10/10/14, when the worker was seen by her treating physician complaining of persistent neck pain headaches, and left shoulder pain. She reported her pain level at 2/10 on the pain scale. She denied any numbness or tingling down her arms, but did report occasional pain in her left elbow. She reported taking Norco daily, Celebrex daily, and Terocin lotion for her pain without any reported side effects. Her collective medication use reportedly reduced her pain by more than 50% and allowed her to have improved activity. Physical examination findings included cervical paraspinal muscle tenderness, negative foraminal closure tests (cervical), lumbar paraspinal spasm with tenderness, normal strength, normal sensory exam, and normal reflexes. She was then offered a C2 block, but the worker declined. She was also recommended to see her spine specialist for a re-consultation to see if there are any other treatment options for her.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Consultation with spine specialist:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 166, 179-180.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7, p. 127

**Decision rationale:** The MTUS/ACOEM Guidelines state that referral to a specialist(s) may be warranted 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 in assessing therapeutic management, determination of medical stability, and permanent residual loss and/or examinee's fitness for return to work, and suggests that an independent assessment from a consultant may be useful in analyzing causation or when prognosis, degree of impairment, or work capacity requires clarification. The ACOEM MTUS Guidelines also states that referral to a surgeon for low back pain is only indicated when the patient exhibits severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies, has activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms, and failure of conservative treatment to resolve disabling radicular symptoms. In the case of this worker, there was evidence of a previous consultation with a spinal surgeon, which led to not having any surgery performed. There was no evidence found in the progress note provided of the worker experiencing any symptoms or signs which would warrant a surgical consult as she reported low pain levels while using her medication, had no reports of radiculopathy, and the physical examination did not reveal any spinal radiculopathy. Therefore, the spinal specialist is not likely to contribute to her treatment plan in a significant way and is not medically necessary.