

<b>Case Number:</b>	CM15-0131724		
<b>Date Assigned:</b>	07/17/2015	<b>Date of Injury:</b>	06/28/2000
<b>Decision Date:</b>	08/13/2015	<b>UR Denial Date:</b>	06/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/08/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California  
 Certification(s)/Specialty: Emergency Medicine

### 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 (IW) is a 52-year-old female who sustained an industrial injury on 06/28/2000. Diagnoses include status post multiple right carpal tunnel surgeries and re-explorations; status post left carpal tunnel release; right and left lateral epicondylitis; left deQuervain's disease; right shoulder dysfunction; cervical radiculopathy with sprain/strain; and right sympathetic dystrophy. Treatment to date has included medication, multiple carpal tunnel surgeries and multiple elbow injections. According to the progress notes dated 4/23/15, the IW reported pain in the bilateral shoulders with restricted range of motion of the bilateral hands. On examination, there was pain over the right lateral epicondylar area, pain in the left mobile wad and lateral epicondylar region and decreased light touch sensation in the median nerve distribution, right greater than left. A Kenalog injection was given into the right lateral epicondyle and mobile wad. Cervical spine MRI dated 10/23/12 showed C4-5, C5-6 and C6-7 spondylosis with degenerative disc disease. The previous AME was conducted on 4/17/14. A request was made for orthopedic cervical spine surgery and re-evaluation by Agreed Medical Evaluation (AME).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Orthopedic spine surgery cervical spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd edition (2004), Chapter 7 Independent Medical Examinations and Consultations, page 127.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain, Part 1: Introduction Page(s): 1.

**Decision rationale:** The requested Orthopedic spine surgery cervical spine, is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 1, Part 1: Introduction, states "If the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary." The injured worker has pain in the bilateral shoulders with restricted range of motion of the bilateral hands. On examination, there was pain over the right lateral epicondylar area, pain in the left mobile wad and lateral epicondylar region and decreased light touch sensation in the median nerve distribution, right greater than left. A Kenalog injection was given into the right lateral epicondyle and mobile wad. Cervical spine MRI dated 10/23/12 showed C4-5, C5-6 and C6-7 spondylosis with degenerative disc disease. The treating physician has not documented sufficient exam and diagnostic evidence that establish that the injured worker is currently a surgical candidate. The criteria noted above not having been met, Orthopedic spine surgery cervical spine is not medically necessary.

**Re-evaluation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd edition (2004), Chapter 7 Independent Medical Examinations and Consultations, page 127.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain, Part 1: Introduction Page(s): 1.

**Decision rationale:** The requested Re-evaluation, is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 1, Part 1: Introduction, states "If the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary."The injured worker has pain in the bilateral shoulders with restricted range of motion of the bilateral hands. On examination, there was pain over the right lateral epicondylar area, pain in the left mobile wad and lateral epicondylar region and decreased light touch sensation in the median nerve distribution, right greater than left. A Kenalog injection was given into the right lateral epicondyle and mobile wad. Cervical spine MRI dated 10/23/12 showed C4-5, C5-6 and C6-7 spondylosis with degenerative disc disease. The treating physician has not documented sufficient exam and diagnostic evidence that establish that the injured worker is currently a surgical candidate. The criteria noted above not having been met, Re-evaluation is not medically necessary.

