

Case Number:	CM15-0202050		
Date Assigned:	10/16/2015	Date of Injury:	02/02/2015
Decision Date:	11/25/2015	UR Denial Date:	10/06/2015
Priority:	Standard	Application Received:	10/14/2015

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: Physical Medicine & Rehabilitation

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 51 year old male, who sustained an industrial injury on 2-2-15. The injured worker was diagnosed as having multilevel degenerative disc disease; cervical herniated nucleus pulposus. Treatment to date has included physical therapy; medications. Diagnostics studies included MRI cervical spine (9-18-15); MRI lumbar spine (2-20-15); PET scan (3-10-15). Currently, the PR-2 notes dated 8-6-15 indicated the injured worker complains of continued low back pain as before. His condition is reported as "not changed very much". He has tried to return to work but he had been replaced and is currently not working, but looking for work. On examination of the lumbar spine, the provider documents "There is slight spasm in the lumbar paraspinous muscles." Range of motion is documented as somewhat limited. The provider notes "Reflexes in the lower extremities are symmetric and normoactive at both the knee and the ankle. Straight leg raising in the sitting position is negative bilaterally. No atrophy is noted in the lower extremities. There is good muscle strength in all muscles in both lower extremities. Toe and help standing is satisfactorily performed. There is a normal range of motion in both hips. There is no sensory deficit in either lower extremity." A PR-2 note dated 7-6-15 is titled "Initial Comprehensive Spinal Surgery Consultation". The provider documents "Severe pain in the middle of back which is present frequently at 10 out of 10 on a scale of 1 to 10, 1 being the lowest level of pain and 10 being the highest, which radiates from the middle left side and aggravated by physical activities requiring prolonged overhead work, positioning the head and sitting with neck flexed and heavy lifting and carrying. Severe pain in the lower back which is present frequently at 10 out of 10 on a scale of 1 to 10, 1 being the lowest level of pain and 10

being the maximum level of pain, located in the midline and on both sides, with greater pain on the left side, radiating proximally to the mid back and distally to the buttocks and posterior aspect of the left hip, leg and left foot causing locking, numbness and tingling, aggravated by physical activities such as bending, stooping, twisting, turning, pushing, pulling, lifting, carrying, overhead reaching, sitting, standing, walking and stair climbing." The provider reviews the mechanism of injury as being "black-out" possibly due to "fumes". He underwent blood work and a CT scan of the head since there was a "bump on the back of head". He has had chiropractic treatment and pain management. He reports he had an epidural injection 6-5-15 and since then he reports he "developed numbness in the left hip as well as sharp pain in the left lower extremity." He reports he has had a compression fracture in the lower back in 1986 and underwent surgery. He has had kidney cancer and underwent a left kidney removal in 2008. He has also had gastric sleeve surgery with subsequent "stomach hernia removal". The provider notes he is currently taking Gabapentin 600mg, Baclofen 10mg and Norco 10-325mg. He also smokes 7-8 cigarettes a day. A MRI of the lumbar spine is documented done on 2-20-15 revealing "This shows multilevel laminectomy at T12-L2, chronic T12-L1 anterior compression fractures, exaggerated kyphosis and mild levoscoliosis. There is 4mm degenerative retrolisthesis at L2-3 and L3-4 multilevel moderate lumbar spondylosis." He also had a PET whole body scan on 3-10-15 with "no definite abnormal focal areas of increased activity in the left abdomen." MRI cervical spine dated 9-18-15 reveals impression "Multilevel degenerative changes with foraminal stenosis affecting the exiting bilateral C5, C6, and C7 nerve roots as detailed. C4-C5 mild broad-based disc osteophytes complex causing mild to moderate spinal canal stenosis. No abnormal bone edema to suggest fracture." A Request for Authorization is dated 10-14-15. A Utilization Review letter is dated 10-6-15 and non-certification for Pain management consultation (cervical spine). A request for authorization has been received for Pain management consultation (cervical spine).

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain management consultation (cervical spine): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM) 2004, Chapter 7, page 127, Independent Medical Examinations and Consultations.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Follow-up Visits.

Decision rationale: This patient sustained a low back injury and continues to be treated for chronic pain. Symptoms are stable without any new trauma and the patient is tolerating conservative treatments without escalation of medication use or clinically red-flag findings on examination. There is no change or report of acute flare. If a patient fails to functionally improve as expected with treatment, the patient's condition should be reassessed by consultation in order to identify incorrect or missed diagnoses. However, this is not the case; the patient remains stable with continued chronic pain symptoms on same unchanged medication profile and clinical exam is without neurological deficits with intact DTRs, motor strength and sensation with negative SLR. Medical necessity for pain management consultation has not been established. There are no clinical findings or treatment plan suggestive for any interventional pain procedure. The Pain management consultation (cervical spine) is not medically necessary and appropriate.