

Case Number:	CM15-0217915		
Date Assigned:	11/09/2015	Date of Injury:	10/09/2008
Decision Date:	12/21/2015	UR Denial Date:	10/26/2015
Priority:	Standard	Application Received:	11/05/2015

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, Indiana, New York
 Certification(s)/Specialty: Internal 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 is a 63 year old female, who sustained an industrial injury on 10-09-2008. A review of the medical records indicates that the worker is undergoing treatment for status post recent cervical 2 level discectomy and fusion and lumbar spondylosis. Treatment has included pain medication, lumbar transforaminal regional epidural steroid injection, physical therapy, surgery and acupuncture. The worker underwent anterior cervical discectomy and fusion of C4-C5 and C5-C6 on 02-17-2015. On 06-03-2015, the worker's symptoms were noted to improve with minimal episodes of left arm pain and objective findings showed well-healed incision and mild tenderness to palpation over the bilateral trapezii. On 07-08-2015, the worker continued to wear a soft cervical collar due to persistent neck pain and a lumbar corset due to persistent back pain. Objective findings showed decreased range of motion of the cervical spine, tenderness of the bilateral trapezii, moderately diminished range of motion of the lumbar spine and tenderness of the lumbosacral midline. Radiographs of the cervical spine on 07-08-2015 were noted to show fusion with instrumentation of C4-C5 and C5-C6 with excellent incorporation of the graft and no evidence of loosening of implants. Subjective complaints (09-24-2015) included significant neck and bilateral upper extremity pain. Objective findings (09-24-2015) included an antalgic gait, tenderness of the low back, decreased range of motion, significant tenderness in the left piriformis region, sciatic notch and ischial tuberosity, decreased sensation in the left L5 and L4 distribution, positive straight leg raise in the left lower extremity and positive motor exam with decreased left ankle dorsiflexion. The physician noted that the worker had 2 falls over the last 2 months that she attributed to catching her toes on the left side and that the worker had evidence for radiculitis and radiculopathy in the left lower extremity. The worker was noted to be a candidate for lumbar surgery but that she had just had neck surgery and did not wish to have another spine surgery yet.

A request for repeat lumbar epidural steroid was noted as being made in addition to a request for follow-up office visit. A utilization review dated 10-26-2015 non-certified a request for re-evaluation office visit, quantity: 1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Re-evaluation office visit, quantity: 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2013, Pain Chapter, updated 06/16/15, Office visits.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Office visits.

Decision rationale: Pursuant to the Official Disability Guidelines, re-evaluation office visit, #1 is not medically necessary. The need for a clinical office visit with a healthcare provider is individualized based upon a review of patient concerns, signs and symptoms, clinical stability and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines as opiates or certain antibiotics require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. Determination of necessity for an office visit requires individual case review and reassessment being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self-care as soon as clinically feasible. In this case, the injured worker's working diagnoses are status both recent cervical 2-level discectomy and fusion; and lumbar spondylosis. Date of injury is October 9, 2008. Request for authorization is September 24, 2015. According to a September 24, 2015 pay management follow-up progress note, subjective complaints include significant neck pain and upper extremity pain. The injured worker status post cervical discectomy and fusion (2-level). Objectively, there is tenderness to palpation lumbar spine paraspinal muscles with decreased range of motion and positive straight like raising. The injured worker has documented lumbar spine disc disease and surgery is recommended. The injured worker is seen by mental health who prescribed Paxil, zolpidem, Fioricet and Xanax. The pain management provider prescribes Norco 10 mg 1 to 2 tablets every six hours. The progress note documentation indicates the injured worker is to be followed every 90 days. The request for authorization dated September 24, 2015 contains a follow-up office visit October 22, 2015 (less than one month) with no clinical indication or rationale. A second request for authorization (also dated September 24, 2015) contains an authorization for reevaluation with the requesting provider at 90 day intervals. There is no specific timeframe referencing the 90 day intervals. There is no clinical indication or rationale for open-ended 90 day interval office visits. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines and progress note documentation indicating follow-up every 90 days, re-evaluation office visit, #1 is not medically necessary.