MAXIMUS Federal Services

Case Number:	CM15-0049234		
Date Assigned:	04/23/2015	Date of Injury:	10/20/2004
Decision Date:	05/20/2015	UR Denial Date:	02/17/2015
Priority:	Standard	Application Received:	03/16/2015

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: New York
Certification(s)/Specialty: Neurological Surgery

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 52 year old female patient who sustained an industrial injury on 10/20/2004. A primary treating office visit dated 02/03/2015 reported subjective complaint of neck, upper/lower back, bilateral shoulders, and bilateral wrists/hands with pain. Of note, she has seen an orthopedic specialist. In addition, she reports over the past two weeks she's noticed cramping in hands especially the right and left forearm burn and feeling of weakness. The following diagnoses are applied: cervical spine disc bulges with radiculopathy; thoracic spine disc bulge; lumbar spine disc bulge; right shoulder tenosynovitis; status post right shoulder surgery 07/13/2012; left shoulder strain; right wrist/hand strain; left wrist/hand strain, and other problems unrelated to current evaluation. A secondary treating office visit dated 08/08/2014 reported subjective complaints of having improved pain and function, by greater than 70%, after administration of cervical epidural on 07/2014. She is diagnosed with cervical radiculopathy. The plan of care involved: continue medications as prescribed; remain active, as tolerated and return for follow up in 6 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

C4-C5 (ACDF) Anterior Discectomy Fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter, Indications for Surgery.

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

Decision rationale: The California MTUS guidelines recommend surgical consultation if the patient is having severe persistent disabling upper extremity symptoms. The documentation does not provide evidence of this. The California guidelines also recommend the presence of clear clinical, imaging and electrophysiological evidence of the presence of a lesion known to have positively responded in the short and long term from surgical repair. Documentation does not provide support of such presence. The California MTUS guidelines do recommend a spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had any of these events. The requested treatment: C4-C5 (ACDF) Anterior Discectomy Fusion is NOT medically necessary and appropriate.

TENS Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Chiropractic Treatment (12-sessions, 2 times a week for 6 weeks): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 173, 298-299, Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter, Cervical Manipulation.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck chapter-Manipulation.

Decision rationale: The ODG guidelines do recommend manipulation as an option for 2-3 weeks. Gentle home exercises were advocated. The requested treatment: Chiropractic Treatment (12-sessions, 2 times a week for 6 weeks) is NOT medically necessary and appropriate.

Shockwave Therapy (ESWT) for the right and left shoulders: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Extracorporeal Shock Wave Therapy (ESWT).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder chapter- Extracorporeal shock wave therapy (ESWT).

Decision rationale: The ODG guidelines do recommend ESWT for calcifying tendonitis in the shoulders. Documentation does not provide evidence the patient has this. ESWT is not recommended for other conditions in the shoulder. The requested treatment: Shockwave Therapy (ESWT) for the right and left shoulders is NOT medically necessary and appropriate.

Cervical Epidural Injection: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46. Decision based on Non-MTUS Citation AMA Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Injections chapter- Epidural steroid injections (ESIs), therapeutic.

Decision rationale: The ODG guidelines note that the ESI is recommended as a short-term treatment for radicular pain and offers an attractive alternative to surgery. Criteria for repeat injection are greater than 50-70% improvement. Documentation shows the patient had 75% improvement. The requested treatment: Cervical Epidural Injection is medically necessary and appropriate.

MRI of the Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Magnetic Resonance Imaging (MRI).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 208-9.

Decision rationale: The California MTUS guidelines do recommend a MRI of the shoulder if a red flag rises. Documentation does not show this has happened. The guidelines recommend a MRI if the suspected pathologic anatomy needs to be clarified. Documentation does not give evidence of this need. The guidelines also support obtaining a MRI if a specific neurovascular dysfunction is found or physiologic evidence of tissue insult. The documentation does not provide support of this. The requested treatment: MRI of the Left Shoulder is not medically necessary and appropriate.