

Case Number:	CM14-0166593		
Date Assigned:	10/13/2014	Date of Injury:	03/12/2014
Decision Date:	11/14/2014	UR Denial Date:	10/06/2014
Priority:	Standard	Application Received:	10/09/2014

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 Internal Medicine and is licensed to practice in California. 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 injured worker is a 39-year-old woman who sustained an injury on March 12, 2014 while lifting a patient working as a Certified Nursing Assistant (CNA). The injured worker was a tobacco smoker and too heavy for any kind of surgical intervention. The injured worker had hypercholesterolemia and asthma. The patient was 63 inches and weighs 198 pounds. She smokes 1 pack of cigarettes a day and has done so for 13 years. X-ray of the lumbosacral spine dated March 14, 2014 documented degenerative disc disease and degenerative joint disease and posterior osteophytes and prominent narrowing of the intervertebral disc spaces from L4 to S1 level. If disc herniations at these levels are clinically possible, magnetic resonance imaging (MRI) of the lumbar spine may be of value. Minimal compression deformity of L1 vertebral body. MRI of the lumbar spine dated April 29, 2014 documented hypolordosis; degenerative disc disease; L2-3 posterior disc protrusion with measurement of approximately 3mm, right posteromedial extruded disc with measurement 9 mm x 4 mm x 7 mm, mild spinal stenosis, and impingement of the right L3 nerve root at the right lateral recess; L3-4 posterior disc protrusion with measurements of approximately 5 mm, mild spinal stenosis, and questionable impingement of the left L4 nerve root at the left lateral recess; L4-5 posterior disc protrusion with measurement of approximately 4 mm, mild spinal stenosis and impingement of the left L5 nerve roots at the left lateral recess; L5-S1 posterior disc protrusion with measurement of approximately 7 mm and mild spinal stenosis; and fissures and annulus fibrosus from L3 to the L5 levels. Electromagnetic studies and nerve conduction studies dated June 2, 2014 documented no evidence of lumbar radiculopathy or peripheral neuropathy on either side of the lower extremities. According to the office note dated September 16, 2014, on the examination of the back, the injured worker was able to walk on heels and toes with some pain in the lower back, more on the heels than on his toes. There was pain on the left in tilting to the right, tilting to the

left caused pain in the middle, and tilting forward caused pain on both sides. The deep tendon reflexes, sub patellar and Achilles were intact. The lower extremities push-pulls were normal. The straight leg raises were positive on the left. The injured worker ambulated without assistance, discomfort or distress. Work restriction included no lifting, pushing, and pulling more than 15 pounds and no repetitive bending. She describes frequent urination and constipation but no loss of bowel or bladder control. She finds valsalva maneuvers increase her discomfort. She has some weakness and pain in the left leg. She describes her pain as 70% in the back and 15% in her leg. Prior treatments included six sessions of physical therapy as of May 7, 2014, without resolution of symptoms. Other treatments have included medications, rectal stimulation, exercises and heat application, exercises, rectal stimulation and heat application. Of note, the patient underwent gastric bypass surgery (undated). The treatment plans included chiropractic therapy, physical therapy, weight loss, and smoking cessation, Neurontin 300mg, 1 tablet every 12 hours #60; Tylenol with Codeine, 1 tablet every 12 hours #30; Robaxin, 1 tablet at bedtime; injection; and a second opinion of a spine specialist for possible injections, and pain management.

IMR ISSUES, DECISIONS AND RATIONALES

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

Second opinion with spine specialist for the lumbar spine: 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)

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

Decision rationale: Pursuant to the Official Disability Guidelines, the request for a second opinion with a spine specialist (as it relates to the lumbar spine report dated September 16, 2014) is not medically necessary. The guidelines recommend evaluation and management of patient services to medical doctors as they play a critical role in the proper diagnosis and return to function in the injured worker. Visits should be encouraged. The need for a clinical office visit with a provider is individualized and based on a review of the patient concerns, signs and symptoms, clinical stability and reasonable physician judgment. Considerations also include medicines the patient is taking and whether the injured worker requires close monitoring. In this case, the injured worker complains of pain in the lower back, worse with certain clinical maneuvers. Straight leg raising was positive in the patient but the injured worker (IW) ambulated without assistance, discomfort or distress. There were the work restrictions in place including no lifting, pushing, and pulling more than 15 pounds and no repetitive bending. Additional treatment plans included chiropractic therapy, physical therapy, weight loss, smoking cessation, Neurontin, Tylenol with Codeine, Robaxin, and a second opinion of the spine specialist. The injured worker had EMG/NCV studies on June 2, 2014. The electrodiagnostic study showed no evidence of lumbar radiculopathy or peripheral neuropathy on either side of the lower extremity. Radiologic studies showed multiple disc bulges and nerve impingements of the lumbar spine. However, the clinical history and physical examination and medical documentation do not

objectively support the request for a second opinion with a spine specialist to evaluate the lumbar spine. There is no documented indication or explanation as to why a second opinion with a spine surgeon is warranted. Clinically, there were no focal neurologic findings despite multiple radiologic disc bulges and nerve impingements and the EMG/NCV showed no evidence of radiculopathy. Additionally, there is no documentation supporting the need for surgery in the face of a normal physical neurological evaluation. Based on the clinical information in the medical record and the peer-reviewed, evidence-based guidelines the second opinion with a spine specialist for the lumbar spine is not medically necessary.