

Case Number:	CM13-0069704		
Date Assigned:	01/03/2014	Date of Injury:	06/08/2000
Decision Date:	04/21/2014	UR Denial Date:	12/02/2013
Priority:	Standard	Application Received:	12/23/2013

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 Pulmonary Diseases 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 patient is a 43-year-old female who reported an injury on 06/08/2000. The mechanism of injury was not provided for review. The patient developed left upper extremity pain. The patient's treatment history has included various medications, physical therapy, and other types of conservative treatment that failed to provide the patient adequate relief. The patient ultimately underwent insertion of an intrathecal pain pump. The patient underwent a thoracic MRI in 04/2013 that documented the patient had mild facet arthropathy from the T9 through the T12. His most recent clinical evaluation dated 11/05/2013 documented that the patient had 9/10 pain without medications reduced to 8/10 pain level with medications. It was noted that the patient had weaned herself off of methadone and required a refill of her pain medications. The patient's diagnoses include complex regional pain syndrome of the upper extremities, complex regional pain syndrome of the lower extremities, status post intrathecal pain pump implant, opioid induced constipation and medication induced sedation. The patient's treatment plan included continuation of medications and refill and maintenance of her intrathecal pain pump.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI THORACIC SPINE WITH AND WITHOUT CONTRAST: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Decision rationale: The ACOEM Guidelines recommends MRIs for patients with documentation of neurological deficits. The patient's most recent clinical documentation does not provide any evidence that the patient has any significant neurological deficits. Additionally, Official Disability Guidelines only recommend repeat imaging in the presence of progressive neurological deficits or a significant change in the patient's pathology. The clinical documentation does indicate that the patient previously underwent a thoracic spine MRI in 04/2013 that did not conclude any significant deficits. The clinical documentation submitted for review does not provide any evidence of a significant change in the patient's clinical presentation to support the need for an additional MRI. The request for MRI of the thoracic spine with and without contrast is not medically necessary and appropriate.