MAXIMUS Federal Services

Case Number:	CM14-0209471		
Date Assigned:	01/21/2015	Date of Injury:	07/23/2013
Decision Date:	03/03/2015	UR Denial Date:	11/17/2014
Priority:	Standard	Application Received:	12/12/2014

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. 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: 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 patient is an injured worker with a history of thoracic back complaints. Date of injury July 23, 2013. The progress report dated April 8, 2014 documented that the patient continues to have thoracic pain. She states that her medication improves her pain, quality of life and improves her sleep. She uses ice and heat as well which is effective rest improves her pain as well. Prolonged lifting pushing and pulling exacerbates her pain. She has a scheduled appointment with the orthopedic surgeon. Patient complains of pain in her neck. The patient has lumbar disc disease. She has had a previous injury of neck or spine. She denies smoking cigarettes or cigars. She denies alcohol use. The patient denies taking any street drugs. Objective findings were documented. There is diffuse tenderness around the proximal thoracic spine and distal thoracic spine there is no scoliosis or kyphosis deformity. Diagnoses were neck sprain and strain and thoracic disc disorder. T6-T7 percutaneous disc decompression was considered. The progress report dated June 4,2014 documented that the patient had a chief complaint of thoracic pain which radiates anteriorly to her sternum when it flares up. Currently she is having mostly just thoracic pain. Medications included Morphine and Norco. This patient has history and pain symptoms consistent with thoracic disc herniation. She has no weakness of the upper or lower extremities. There is tenderness over the thoracic spine paraspinous. Diagnoses were neck sprain and strain and thoracic disc disorder. Utilization review determination date was November 17, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat MRI of the Thoracic 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), Low Back Procedure Summary last updated 8/22/2014

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179, 181-183.

Decision rationale: ACOEM, 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints states that reliance on imaging studies alone to evaluate the source of neck or upper back symptoms carries a significant risk of diagnostic confusion (false-positive test results). Table 8-8 Summary of Recommendations for Evaluating and Managing Neck and Upper Back Complaints (Page 181-183) states that radiography are the initial studies when red flags for fracture, or neurologic deficit associated with acute trauma, tumor, or infection are present. MRI may be recommended to evaluate red-flag diagnoses. Imaging is not recommended in the absence of red flags. MRI may be recommended to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. The latest progress reports present in the submitted medical records were dated April 8, 2014 and June 4,2014. Utilization review determination date was November 17, 2014. No progress reports from October or November 20124 were present in the submitted medical records. Without updated progress reports, the request for thoracic spine MRI magnetic resonance imaging is not supported. Therefore, the request for repeat MRI of the thoracic spine is not medically necessary.

Repeat T6-7 interlaminar epidural steroid injection under fluoroscopic guidance: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs). Page(s): 46.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines (Page 46) states that epidural steroid injections (ESI) are an option for radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The American Academy of Neurology recently concluded that there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. ESI treatment alone offers no significant long-term functional benefit. Criteria for the use of epidural steroid injections requires that radiculopathy must be documented by physical examination and corroborated by imaging studies or electrodiagnostic testing. The latest progress reports present in the submitted medical records were dated April 8, 2014 and June 4,2014. Utilization review determination date was November 17, 2014. No progress reports from October or November 20124 were present in the submitted medical records. Without updated progress reports, the request for T6-7 epidural

steroid injection is not supported. Therefore, the request for repeat T6-7 interlaminar epidural steroid injection under fluoroscopic guidance is not medically necessary.

Prospective review- Toxicology screening/report: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers' Compensation (ODG-TWC), Pain Procedure Summary (updated 10/2/14), Urine drug testing

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing; Opioids, Criteria For Use; Opioids, Pain Treatment Agreement; and Opioids, Steps.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines address drug testing. Drug testing is recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. Frequent random urine toxicology screens are recommended as a step to avoid misuse and addiction of opioids. Urine drug screens may be required for an opioid pain treatment agreement. Urine drug screen to assess for the use or the presence of illegal drugs is a step to take for the use of opioids. The latest progress reports present in the submitted medical records were dated April 8, 2014 and June 4, 2014. Utilization review determination date was November 17, 2014. No progress reports from October or November 20124 were present in the submitted medical records. Without updated progress reports, the request for toxicology screen is not supported. Therefore, the request for toxicology screening and report is not medically necessary.