

Case Number:	CM15-0188069		
Date Assigned:	09/30/2015	Date of Injury:	02/18/2011
Decision Date:	11/12/2015	UR Denial Date:	08/24/2015
Priority:	Standard	Application Received:	09/24/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 February 18, 2011. A urine drug screening performed on August 05, 2015 reported the findings inconsistent with the patient's prescribed medications. Another urine drug screening performed on May 13, 2015 reported findings inconsistent with the patient's prescribed medications. A recent primary treating office visit dated August 05, 2015 reported the worker with longstanding neck and low back complaints. There is note of discussion regarding a MRI to be performed, was authorized but the worker is claustrophobic and cannot tolerate a closed MRI. The authorization has since lapsed and there is new recommendation for a MRI standing unit along with orthopedic referral for spine evaluation. Current objective findings showed urine sample collected. Current medications consisted of: Tylenol with Codeine, Motrin, and Flexeril prescribed by primary treating. The impression found the worker with: cervical discogenic disease status post cervical fusion with ongoing pain and decreased range of motion of the cervical spine; lumbar discogenic disease with anterior listhesis and retrolisthesis (this is a new findings since the last MRI of 1997). In addition, MRI performed on August 05, 2014 reported findings consistent with anterior listhesis of L2 on L3 and retrolisthesis of L5-S1. She is also to undergo another course of physical therapy treating the neck. On August 12, 2015 a request was made for MRI of cervical spine and drug urine screening which were both denied by utilization review on August 24, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (acute and chronic) Chapter, under Magnetic Resonance Imaging.

Decision rationale: The 63 year old patient complains of ongoing neck and lower back pain, as per progress report dated 08/05/15. The request is for MRI cervical spine. The RFA for this case is dated 08/17/15, and the patient's date of injury is 02/18/11. The patient is status post C4-C7 fusion in 2006, as per progress report dated 08/05/15. Diagnoses also included cervical discogenic disease and lumbar discogenic disease. Medications included Motrin, Flexeril, Hydrochlorothiazide, Metformin and Tylenol with codeine. As per progress report dated 05/13/15, the neck pain radiates to the patient's shoulders and the lower back pain radiates to the right leg. The patient has retired recently, as per progress report dated 08/05/15. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8, Neck and Upper Back, pages 177-178 under "Special Studies and Diagnostic and Treatment Considerations" states: "Neck and upper back complaints, under special studies and diagnostic and treatment considerations: Physiologic evidence of tissue insult or neurologic dysfunction. It defines physiologic evidence as a form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans." ACOEM further states that "unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient imaging to warrant imaging studies if symptoms persist." ODG Guidelines, Neck and Upper Back (acute and chronic) Chapter, under Magnetic Resonance Imaging states: Not recommended except for indications listed below. Indications for imaging MRI: Chronic neck pain (equals after 3 months of conservative treatment), radiographs are normal, neurologic signs or symptoms present. Neck pain with radiculopathy of severe or progressive neurologic deficit. In this case, a request for cervical MRI is noted in progress report dated 08/05/15. The patient complains of chronic neck pain, and physical examination of the cervical spine revealed decreased range of motion along with reduced sensation to pain and touch in C7 dermatomal distribution. The treater states that the patient has claustrophobia and will, therefore, require a standing MRI in an open unit. In the same report, the treater indicates that the patient "has had experience of doing cervical MRI in an open unit". The treater also documents that "I have a cervical MRI that shows status post fusion C4 through C7. I have a lumbar MRI that shows anterior listhesis of L2 on L3 and retrolisthesis of L5-S1. It should be noted that this was done on August 05, 2014." It is not clear if both cervical and lumbar MRI were done in 2014 or not. A cervical imaging study from 06/19/14 (not clear if this an MRI), revealed bulging and osteophyte formation at C2-3, C3-4 and C4-5 along with spinal stenosis and foraminal narrowing. This report is incomplete as multiple pages are missing. A 2006 cervical MRI revealed disc desiccation from C3 to T1 along with osteophyte complex and large HNP impinging right C6-7 foramina. While the patient does suffer from neck pain and neurologic deficit, the reports do not indicate the dates and findings of prior cervical

MRIs. ODG allows for repeat MRIs only if there has been a progression of neurologic deficit or in presence of specific red flags. Given the lack of relevant documentation, the request is not medically necessary.

Retrospective urine drug screen for DOS 8/5/15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter under Urine Drug Screen.

Decision rationale: The 63 year old patient complains of ongoing neck and lower back pain, as per progress report dated 08/05/15. The request is for Retrospective urine drug screen for DOS 8/5/15. The RFA for this case is dated 08/17/15, and the patient's date of injury is 02/18/11. The patient is status post C4-C7 fusion in 2006, as per progress report dated 08/05/15. Diagnoses also included cervical discogenic disease and lumbar discogenic disease. Medications included Motrin, Flexeril, Hydrochlorothiazide, Metformin and Tylenol with codeine. As per progress report dated 05/13/15, the neck pain radiates to the patient's shoulders and the lower back pain radiates to the right leg. The patient has retired recently, as per progress report dated 08/05/15. MTUS Chronic Pain Medical Treatment Guidelines 2009, p77, Criteria for use of Opioids Section, under Opioid management: (j) "Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs." ODG-TWC, Pain Chapter under Urine Drug Screen states: "Patients at "low risk" of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. There is no reason to perform confirmatory testing unless the test is inappropriate or there are unexpected results. If required, confirmatory testing should be for the questioned drugs only. Patients at "moderate risk" for addiction/aberrant behavior are recommended for point-of-contact screening 2 to 3 times a year with confirmatory testing for inappropriate or unexplained results. Patients at "high risk" of adverse outcomes may require testing as often as once per month. This category generally includes individuals with active substance abuse disorders." In this case, the patient is taking Tylenol with codeine, and is required to undergo urine drug screening to address aberrant behavior. A review of the available progress reports indicates that the patient has undergone toxicology screening on 02/24/15, 04/14/15, 05/13/15, and 08/05/15. While the 02/24/15 report was consistent, subsequent reports dated 04/14/15; 05/13/15 and 08/05/15 were inconsistent, based on the respective Urine Toxicology Review reports from the treater. This is a retrospective request for the 08/05/15 test. The treater does not document the patient's opioid risk assessment nor does the treater discuss what is to be done with the inconsistent results. There is no discussion as to why more and more UDS's are obtained when the results are inconsistent. The request is not medically necessary.