

<b>Case Number:</b>	CM15-0200385		
<b>Date Assigned:</b>	10/14/2015	<b>Date of Injury:</b>	06/19/2014
<b>Decision Date:</b>	11/25/2015	<b>UR Denial Date:</b>	09/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/28/2015

### 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 54 year old male, who sustained an industrial injury on 6-19-14. The documentation on 12-23-14 noted that the injured worker has complaints of upper back pain with a pain level of 7 to 8 out of 10 on the pain scale and is associated with headaches extending from the occiput to the frontalis and the injured worker has reports of left peripheral vision loss. The injured worker has complaints of low back pain rated as a 7 to 8 out of 10 of the pain scale. The injured worker states that his pain interferes with his activities of daily living, including standing, sitting and walking. Head examination revealed decreased vision on the left; pupils equally round and reactive to light; visual fields intact to 10 feet; extraocular motion intact and decreased peripheral vision of the left, right within normal limits. Thoracolumbar spine examination revealed positive tenderness to palpation along the vertebral bodies at T10 suspect fracture versus herniated nucleus pulposus (HNP) and positive myospasms. Sitting and supine straight leg raise is positive on the left. Right knee examination has positive crepitus; positive McMurray's and positive popliteal cyst. The diagnoses have included thoracic or lumbosacral neuritis or radiculitis, unspecified; sprains and strains of other and unspecified parts of back; lumbago and cervicgia. Treatment to date has included cyclobenzaprine; cyclobenzaprine cream; gabapentin; acupuncture; physiotherapy; lumbar-sacral orthosis brace and heat therapy. The request was for magnetic resonance imaging (MRI) of the thoracic spine and lumbar spine to rule out internal derangement and X-rays of the cervical, thoracic and lumbar spine to rule out fracture (compression at T10). Magnetic resonance imaging (MRI) of the thoracic spine on 1-5-15 revealed no discogenic spondylosis, moderate at T6 to T11; mild at T11 to L1 and no other

significant abnormalities. Thoracic spine X-rays on 1-5-15 revealed degenerative right lateral endplate osteophytes are seen off of mid thoracic vertebrae and lower thoracic vertebrae and degenerative anterior superior and anterior inferior endplate osteophytes are seen off of mid thoracic vertebrae. The original utilization review (9-10-15) non-certified the request for thoracic X-ray performed on 1-5-15 and thoracic magnetic resonance imaging (MRI) performed on 1-5-15.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Thoracic X-Ray: Overturned**

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

**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 - Lumbar & Thoracic (Acute & Chronic) Chapter under Radiography.

**Decision rationale:** The current request is for Thoracic x-ray. Treatment to date has included cyclobenzaprine; cyclobenzaprine cream; gabapentin; acupuncture; physiotherapy; lumbar-sacral orthosis brace and heat therapy. The patient is TTD. ODG-TWC, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter under Radiography (x-rays) states: Not recommend routine x-rays in the absence of red flags. (See indications list below.) Indications for imaging -- Plain #-rays: Thoracic spine trauma: severe trauma, pain, no neurological deficit- Thoracic spine trauma: with neurological deficit. Per report 12/21/14, the patient presents with complaints of upper back pain with associated headaches extending from the occiput to the frontalis. Thoracolumbar spine examination revealed positive tenderness to palpation along the vertebral bodies at T10 suspect fracture versus herniated nucleus pulposus (HNP) and positive myospasm. Sitting and supine straight leg raise is positive on the left. The request was for magnetic resonance imaging (MRI) of the thoracic spine rule out internal derangement and x-rays of the thoracic spine to rule out fracture (compression at T10). Both imaging were obtained prior to authorization on 01/05/15. In regard to the thoracic spine x-rays, ODG supports such imaging in cases of severe trauma or if there is neurological deficit. Review of the medical file indicates that the patient's mechanism of injury is from a slip and fall, with no indication of severe trauma. However, there is positive sitting and supine straight leg raise on the left, and ODG does support thoracic spine x-rays when neurological deficits are present. Therefore, the request was medically necessary.

#### **Thoracic MRI: Overturned**

**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) Low back chapter under MRIs.

**Decision rationale:** The current request is for thoracic MRI. Treatment to date has included cyclobenzaprine; cyclobenzaprine cream; gabapentin; acupuncture; physiotherapy; lumbar-sacral orthosis brace and heat therapy. The patient is TTD. ACOEM Guidelines, chapter 8, Neck and Upper Back Complaints 2004, Special Studies, page 177 and 178, state "Unequivocal objective findings that identify specific nerve compromise on the neurological examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option." ODG guidelines, Low back chapter under MRIs (magnetic resonance imaging) (L-spine) state that "for uncomplicated back pain MRIs are recommended for radiculopathy following at least one month of conservative treatment." ODG Guidelines do not support MRIs unless there are neurologic signs/symptoms present. Per report 12/21/14, the patient presents with complaints of upper back pain with associated headaches extending from the occiput to the frontalis. Thoracolumbar spine examination revealed positive tenderness to palpation along the vertebral bodies at T10 suspect fracture versus herniated nucleus pulposus (HNP) and positive myospasm. Sitting and supine straight leg raise is positive on the left. The request was for magnetic resonance imaging of the thoracic spine rule out internal derangement and x-rays of the thoracic spine to rule out fracture (compression at T10). Both imaging were obtained prior to authorization on 01/05/15. The patient presents with significant back pain, and examination revealed positive straight leg raise. The treater would like an MRI for further evaluation. An MRI at this juncture is reasonable and may assist the treater in determining treatment route. The requested MRI was medically necessary.