MAXIMUS Federal Services

Case Number:	CM14-0215087		
Date Assigned:	01/26/2015	Date of Injury:	07/23/2013
Decision Date:	03/27/2015	UR Denial Date:	11/17/2014
Priority:	Standard	Application Received:	12/22/2014

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, Arizona
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 35 year old female who suffered a work related injury on 07/23/13. Per the physician notes from 10/22/14, she complains of neck and mid back pain. The treatment plan consists of EMG/NCV of the bilateral lower extremities, thoracic ESI T6-7, MRI of the thoracic spine, Norco, Neurontin, flexeril, consideration of a surgical consultation after the MRI, and toxicology screen. On 11/17/14, the Claims Administrator non-certified the toxicology screen and MRI citing ECG guidelines. The thoracic ESI was non-certified citing MTUS guidelines. The non-certified treatments were subsequently appealed for Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prospective preview - toxicology screening/report: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC, Urine Drug Testing (UDT)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43.

Decision rationale: The prospective preview toxicology screening/report is not medically necessary or appropriate. The injured worker was evaluated on 10/22/2014. The injured worker's medications included Flexeril 10 mg, Neurontin 300 mg, Norco 10/325 mg, ibuprofen 600 mg, Xanax 1 mg, and Wellbutrin 75 mg. It was noted that the injured worker's previous treatment history included a TENS unit, physical therapy, resting, multiple medications, and a functional restoration program. It was noted that the injured worker underwent an MRI of the thoracic spine in 08/2013 that documented scoliosis with moderate spondylosis and left paramedian T6-7 disc protrusion. The injured worker's diagnoses included thoracic pain. Physical findings included tenderness to palpation of the lumbar paravertebral musculature and thoracic paravertebral musculature with decreased sensation over the chest wall. The injured worker's treatment plan included an EMG/NCV of the bilateral lower extremities, a thoracic epidural steroid injections, a repeat MRI of the thoracic spine, a refill of medications, and a urine drug screen. A Request for Authorization was submitted to support the request on 11/11/2014. The California Medical Treatment Utilization Schedule recommends monitoring for aberrant behavior for patients on chronic opioid usage. The clinical documentation submitted for review does indicate that the injured worker is on chronic opioid therapy. However, the clinical documentation does not provide any evidence of symptoms of withdrawal or overuse to support the need for a urine drug screen. As such, the requested perspective preview toxicology screening/report is not medically necessary or appropriate.

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-TWC, Low Back Procedure Summary and Canale: Campbell's Operative Orthopaedics, 10th ed. Chapter 39, Lower Back Pain and Disorders of Intervertebral Discs.

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 Chapter, MRI

Decision rationale: The requested repeat MRI of the thoracic spine is not medically necessary or appropriate. The injured worker was evaluated on 10/22/2014. The injured worker's medications included Flexeril 10 mg, Neurontin 300 mg, Norco 10/325 mg, ibuprofen 600 mg, Xanax 1 mg, and Wellbutrin 75 mg. It was noted that the injured worker's previous treatment history included a TENS unit, physical therapy, resting, multiple medications, and a functional restoration program. It was noted that the injured worker underwent an MRI of the thoracic spine in 08/2013 that documented scoliosis with moderate spondylosis and left paramedian T6-7 disc protrusion. The injured worker's diagnoses included thoracic pain. Physical findings included tenderness to palpation of the lumbar paravertebral musculature and thoracic paravertebral musculature with decreased sensation over the chest wall. The injured worker's treatment plan included an EMG/NCV of the bilateral lower extremities, a thoracic epidural steroid injections, a repeat MRI of the thoracic spine, a refill of medications, and a urine drug screen. A Request for Authorization was submitted to support the request on 11/11/2014. The California Medical Treatment Utilization Schedule does not address repeat imaging. The

Official Disability Guidelines do not support repeat imaging in the absence of signs and symptoms consistent with a significant change in pathology or progressive neurological symptoms. The clinical documentation submitted for review does not provide any evidence that the injured worker has any type of progressive symptoms that would support the need for additional imaging. As such, the requested repeat MRI of the thoracic spine is not medically necessary or appropriate.

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

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of epidural steroid injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Thoracic Epidural Steroid Injections

Decision rationale: The requested repeat T6-7 interlaminar epidural steroid injection under fluoroscopic guidance is not medically necessary or appropriate. The injured worker was evaluated on 10/22/2014. The injured worker's medications included Flexeril 10 mg, Neurontin 300 mg, Norco 10/325 mg, ibuprofen 600 mg, Xanax 1 mg, and Wellbutrin 75 mg. It was noted that the injured worker's previous treatment history included a TENS unit, physical therapy, resting, multiple medications, and a functional restoration program. It was noted that the injured worker underwent an MRI of the thoracic spine in 08/2013 that documented scoliosis with moderate spondylosis and left paramedian T6-7 disc protrusion. The injured worker's diagnoses included thoracic pain. Physical findings included tenderness to palpation of the lumbar paravertebral musculature and thoracic paravertebral musculature with decreased sensation over the chest wall. The injured worker's treatment plan included an EMG/NCV of the bilateral lower extremities, a thoracic epidural steroid injections, a repeat MRI of the thoracic spine, a refill of medications, and a urine drug screen. A Request for Authorization was submitted to support the request on 11/11/2014. The California Medical Treatment Utilization Schedule recommends repeat injections followed by at least 50% pain relief for 6 to 8 weeks with documented functional benefit from the initial injection. The clinical documentation submitted for review does indicate that the injured worker reports benefit from a previous injection. However, quantitative objective findings of functional benefit and pain relief and a duration of that relief were not provided. Furthermore, the Official Disability Guidelines do not support the use of thoracic epidural steroid injections. As such, the requested repeat T6-7 interlaminar epidural steroid injection under fluoroscopic guidance is not medically necessary or appropriate.