

<b>Case Number:</b>	CM13-0034707		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	05/02/2008
<b>Decision Date:</b>	01/30/2014	<b>UR Denial Date:</b>	10/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/15/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician 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 physician 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 56-year-old female who reported an injury on 05/02/2008 due to standing on a chair that moved causing her to fall. The patient reportedly injured her low back, shoulders, neck, and upper extremities. The patient was initially treated with medications. The patient underwent electrodiagnostic studies that did not reveal any abnormal findings. The patient was seen by a rheumatologist that determined the patient's diagnoses included fibromyalgia. The patient's chronic pain was managed with narcotics and muscle relaxers. The patient underwent MRI of the left shoulder that concluded the patient was status post partial removal of the distal clavicle and acromioclavicular joint, there was limited supraspinatus tendinosis without frank tearing, and a probable congenital sublabral recess. The patient's most recent clinical evaluation revealed restricted lumbar range of motion described as forward flexion to the knees, lateral bending on the right at 0 degrees to 10 degrees, and on the left 20 degrees to 30 degrees with extension measured at 0 degrees to 10 degrees. It was noted that there was a negative straight leg raise test bilaterally and sensation to light touch was intact. The clinical documentation also notes the patient underwent 2 previous MRIs that did not provide any evidence of nerve root impingement. The patient's diagnoses included lumbar disc displacement and low back pain. The patient's treatment plan included shoulder specialist and continuation of medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**A consultation with a shoulder specialist:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7, page 127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 6, page 163.

**Decision rationale:** The consultation with a shoulder specialist is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence the patient has chronic low back pain and widespread pain complaints related to fibromyalgia. American College of Occupational and Environmental Medicine recommends specialty consultations when additional expertise is needed in the treatment of a complicated case. The clinical documentation submitted for review does not provide any evidence that the patient has significant shoulder deficits that would require additional expertise from a shoulder specialist. The clinical documentation submitted for review does not provide any evidence that the patient is a surgical candidate or that the patient has significant deficits that would benefit from consultation with a shoulder specialist. As such, the requested consultation with a shoulder specialist is not medically necessary or appropriate.

**A cervical MRI:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

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

**Decision rationale:** The requested cervical MRI is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence the patient has chronic low back pain. American College of Occupational and Environmental Medicine recommends imaging when there is clinically evident nerve root compromise. The clinical documentation submitted for review does not provide any recent evaluation of the cervical spine that identifies neurological deficits that would warrant the need for an imaging study. As such, the requested cervical MRI is not medically necessary or appropriate

**a thoracic MRI:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** The requested thoracic MRI is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence the patient has chronic low back pain. American College of Occupational and Environmental Medicine recommends imaging when there is clinically evident nerve root compromise. The clinical documentation

submitted for review does not provide any recent evaluation of the thoracic spine that identifies neurological deficits that would warrant the need for an imaging study. As such, the requested thoracic MRI is not medically necessary or appropriate.

**MRI of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:**

**Elavil 50mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain & Anti-depressants Page(s): 60.

**Decision rationale:** The requested Elavil 50 mg is not medically necessary or appropriate. The clinical documentation submitted for review does support the patient has chronic pain complaints. California Medical Treatment Utilization Schedule does recommend antidepressants for management of a patient's chronic pain. However, California Medical Treatment Utilization Schedule also recommends continued use of medications for chronic pain be supported by increased functional benefit and symptom response. The clinical documentation submitted for review does not provide any evidence of increased functional benefit or pain relief as result of this medication. As such, the requested Elavil 50 mg is not medically necessary or appropriate

**Oxycontin 10mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80-81.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Ongoing Management, Page(s): 78.

**Decision rationale:** The requested OxyContin 10 mg is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence the patient has been on this medication for an extended duration of time. California Medical Treatment Utilization Schedule recommends the ongoing use opioids in the management of the patient's chronic pain to include increased functional benefit, documentation of pain relief, management of side effects, and evidence of monitoring for aberrant behavior. The clinical documentation submitted for review does provide evidence that the patient is regularly monitored through urine drug screens.

However, significantly increased functional benefit and pain relief were not addressed within the documentation as it is related to this medication. As such, the requested OxyContin 10 mg is not medically necessary or appropriate.

**Voltaren gel:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** The requested Voltaren gel is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has chronic pain complaints and multiple pain generators. California Medical Treatment Utilization Schedule recommends the use of topical non-steroidal anti-inflammatory drugs when the patient is intolerant or oral formulations are contraindicated for the patient. The clinical documentation submitted for review does not provide any evidence the patient has any contraindications or is intolerant of oral formulations of non-steroidal anti-inflammatory drugs. Additionally, California Medical Treatment Utilization Schedule states that there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder. The clinical documentation submitted for review does provide evidence the patient has multiple pain generators. However, the area that this topical agent is to be used for is not specifically identified. As it is not indicated for osteoarthritis of the spine, this medication would not be supported. As such, the requested Voltaren gel is not medically necessary or appropriate.