

<b>Case Number:</b>	CM13-0038597		
<b>Date Assigned:</b>	12/18/2013	<b>Date of Injury:</b>	01/18/2013
<b>Decision Date:</b>	02/25/2014	<b>UR Denial Date:</b>	10/15/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/25/2013

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 57-year-old male who reported an injury on 01/18/2013 after lifting a heavy box, which caused pain in the right shoulder and lumbar spine. Prior treatments included physical therapy, medications and epidural steroid injections. The patient underwent an MRI that revealed multilevel disc bulging and facet arthropathy. The patient also underwent an EMG/NCV of the bilateral upper extremities that revealed moderate to severe carpal tunnel syndrome. An MRI of the right shoulder revealed a partial thickness tear of the supraspinatus and anteroinferior labrum. The patient's most recent clinical examination findings included tenderness to palpation over the volar aspect of the bilateral wrists with positive bilateral Phalen's test. Examination of the right shoulder revealed tenderness to palpation over the anterior and posterior aspects with positive Neer's and Hawkins tests. Evaluation of the lumbar spine revealed tenderness to palpation over the lumbosacral paraspinal musculature and spinous process. The patient's diagnoses included left shoulder impingement, right shoulder acromioclavicular joint arthropathy with a partial thickness rotator cuff tear and degenerative labral injury, a chronic cervical sprain/strain, a chronic cervicolumbar sprain/strain and bilateral carpal tunnel syndrome as well as bilateral chronic wrist sprains/strains/tenosynovitis. The patient's treatment plan included an L3-S1 discogram and pre-operative psychological clearance.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10mg, #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management Page(s): 78.

**Decision rationale:** The Physician Reviewer's decision rationale: The requested Norco 10 mg #60 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has chronic pain that would benefit from medication management. The California Medical Treatment Utilization Schedule recommends that ongoing use of opioids for patients with chronic pain be supported by a quantitative pain assessment, evidence of functional benefit, monitoring for aberrant behavior and managed side effects. The clinical documentation submitted for review does not provide any evidence that the patient has any pain relief, functional benefit or is monitored for aberrant behavior. Therefore, continued use of this medication would not be supported by guideline recommendations. As such, the requested Norco 10 mg #60 is not medically necessary or appropriate.

**Outpatient Discogram of the lumbar spine at L3-S1:** 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).

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

**Decision rationale:** The Physician Reviewer's decision rationale: The requested outpatient discogram of the lumbar spine at the L3-S1 levels is not medically necessary or appropriate. [REDACTED] does not support the use of discogram as a pre-operative indication for spinal surgery. However, the A [REDACTED] states that although there is a lack of strong medical evidence supporting discography, it is fairly common and should only be considered for surgical candidates who have satisfactory results from a detailed psychological assessment and have failed to respond to conservative treatment. The patient was evaluated on 09/11/2013 by an orthopedic surgeon who documented that the patient underwent a spine laminectomy, laminotomy and fusion and bone grafts in 04/2013. Although this statement is not supported by documentation provided by other providers, clarification of the patient's surgical history would be needed prior to additional treatment planning, to include spinal surgery. As such, the requested outpatient discogram of the lumbar spine at the L3-S1 levels is not medically necessary or appropriate.

**Pre-operative psychological clearance by [REDACTED]** 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).

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

**Decision rationale:** The Physician Reviewer's decision rationale: The requested pre-operative psychological clearance by [REDACTED] is not medically necessary or appropriate. [REDACTED] does recommend psychological clearance prior to performing a discogram. However, the clinical documentation provided for review has conflicting evidence regarding the patient's surgical history. This would need to be clarified prior to further surgical planning. As such, the requested pre-operative psychological clearance by [REDACTED] is not medically necessary or appropriate.

**Post-operative physical therapy 3 x week for 3 weeks:** 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).

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 25.

**Decision rationale:** The Physician Reviewer's decision rationale: The requested postoperative physical therapy 3 times a week for 3 weeks is not medically necessary or appropriate. The submitted documentation provides conflicting evidence about the patient's surgical history. Therefore, additional surgical planning is not supported without clarification of the patient's treatment history. The California Medical Treatment Utilization Schedule does recommend postoperative physical therapy. However, as the clinical documentation submitted for review does not clearly identify the patient as a surgical candidate, postoperative physical therapy would not be indicated. As such, the requested postoperative physical therapy 3 times a week for 3 weeks is not medically necessary or appropriate.