

<b>Case Number:</b>	CM14-0113216		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	09/15/2013
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	06/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/21/2014

### 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. The expert reviewer is Board Certified in Emergency 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 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/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 injured worker is a 53-year-old male who reported an injury on 09/15/2013. The mechanism of injury was reported while the injured worker was throwing a football. The diagnoses included cervical radiculopathy and cervicgia. The previous treatments included medication, TENS unit, physical therapy, and chiropractic sessions. Within the clinical note dated 04/15/2014, it was reported the injured worker complained of neck, right shoulder, and right upper extremity pain. He complained the pain radiated down the right arm all the way down to the rest with numbness and tingling. He rated his pain 4/10 in severity. On physical examination of the cervical spine, the provider noted the injured worker to have full range of motion of the cervical spine, but right lateral rotation and extension increased pain. The injured worker had a positive Spurling's test. The provider noted the injured worker to have tenderness to palpation on the right side of the neck. The provider noted the right shoulder had a negative Hawkins, but positive Neer's test. The provider indicated the injured worker to have tenderness to palpation of the shoulder complex. The provider indicated the injured worker had weakness of the right shoulder muscles due to pain. The provider requested Relafen for shoulder pain, Ultracet for shoulder pain, MRI of the cervical spine, and an MRI of the right shoulder due to significant pain. Request for authorization was submitted and dated on 06/20/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Relafen 750 mg, 1 tab, twice a day for the cervical and right shoulder pain, Quantity 120:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Relafen (nabumetone).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 66-67.

**Decision rationale:** The request for Relafen 750 mg 1 tablet twice a day for the cervical spine and right shoulder pain #120 is not medically necessary. California Medical Treatment Utilization Schedule (MTUS) Guidelines recommend non-steroidal anti-inflammatory drugs (NSAIDs) at the lowest dose for the shortest period of time. The guidelines not NSAIDs are recommended for the signs and symptoms of osteoarthritis. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The clinical documentation submitted did not indicate the injured worker is treated for osteoarthritis. Therefore, the request is not medically necessary.

**Ultracet 37.5/325 mg, 1-4 tabs per day as needed for the cervical and right shoulder pain, Quantity 240:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ultracet (tramadol) Page(s): 113.

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

**Decision rationale:** The request for Ultracet 37.5/325 mg 1 to 4 tablets per day as needed for the cervical and right shoulder pain #240 is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. The provider did not document an adequate and complete pain assessment within the documentation. There is a lack of documentation indicating the medication had been providing objective functional benefit and improvement. Additionally, the use of a urine drug screen was not submitted for clinical review. Therefore, the request is not medically necessary.

**Magnetic Resonance Imaging (MRI) of the cervical spine:** Upheld

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

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

**Decision rationale:** The request for magnetic resonance imaging (MRI) of the cervical spine is not medically necessary. The American College of Occupational and Environmental Medicine

(ACOEM) Guidelines note that criteria for ordering imaging studies include emergence of red flags, physiologic evidence of tissue insult or neurological dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to invasive procedure. There is a lack of significant neurological deficits such as decreased sensation of motor strength in a specific dermatomal or myotomal distribution. There is a lack of documentation indicating the failure of conservative treatment. Additionally, there was no indication of red flag diagnoses or the intent to undergo surgery requiring an MRI. Therefore, the request is not medically necessary.

**Magnetic Resonance Imaging (MRI) of the right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

**Decision rationale:** The request for magnetic resonance imaging (MRI) of the right shoulder is not medically necessary. The American College of Occupational and Environmental Medicine (ACOEM) Guidelines note routine MRI or arthrography for evaluation without surgical indication is not indicated. For most patients with shoulder problems, special studies are not needed unless a 4 to 6 week period of conservative care and observations fails to improve symptoms. There is a lack of documentation indicating the failure of conservative care without the improvement of symptoms. There is a lack of neurological deficits, such as decreased sensation and motor strength in a specific dermatomal or myotomal distribution. Therefore, the request is not medically necessary.