

<b>Case Number:</b>	CM13-0034256		
<b>Date Assigned:</b>	12/06/2013	<b>Date of Injury:</b>	02/14/2002
<b>Decision Date:</b>	03/19/2015	<b>UR Denial Date:</b>	09/13/2013
<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 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, Pain Management

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a patient with a date of injury of 2/14/02. A utilization review determination dated 9/13/13 recommends non-certification of right shoulder MRI, x-rays of the right shoulder, right elbow, and lumbar spine, Flexeril, Neurontin, and Medrol Dosepak. PT was modified from 12 sessions to 8 sessions. 9/4/13 medical report identifies right shoulder, elbow, wrist, and lumbar pain. On exam, shoulder flexion is 150 and abduction is 140. There is rotator cuff weakness and a positive drop arm test. 11/13/13 medical report identifies right shoulder, elbow, and wrist pain as well as lumbar pain. No help with PT. On exam, the right shoulder forward flexion was 120 and abduction was 90.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 3 times a week for 4 weeks for the Right Shoulder, Right Elbow and Lumbar Spine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** Regarding the request for Physical Therapy 3 Times A Week Times 4 Weeks For The Right Shoulder, Right Elbow, And Lumbar Spine, California MTUS supports up to 10 PT sessions and cites that "patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." Within the documentation available for review, the documentation suggests that the patient has not had PT for some time and there are some deficits noted on exam. The previous utilization review modified the request from 12 sessions to 8 sessions. A few PT sessions are appropriate, but the 12 sessions requested are not supported and, unfortunately, there is no provision to modify the current request. In light of the above issues, the currently requested Physical Therapy 3 Times A Week Times 4 Weeks For The Right Shoulder, Right Elbow, And Lumbar Spine is not medically necessary.

**X-Rays of the Right Shoulder, Right Elbow and Lumbar Spine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 12 Low Back Complaints.

**Decision rationale:** Regarding the request for X-Rays Of The Right Shoulder, Right Elbow, And Lumbar Spine, California MTUS supports imaging in the presence of red flags, failure to progress in a rehabilitation program, and for clarification of the anatomy prior to an invasive procedure. Within the documentation available for review, there is no documentation of any red flags, a pending invasive procedure, or another clear rationale for radiographic imaging given that there was a pending course of physical therapy. In light of the above issues, the currently requested X-Rays Of The Right Shoulder, Right Elbow, And Lumbar Spine is not medically necessary.

**Flexeril 10 MG, #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

**Decision rationale:** Regarding the request for Flexeril, CA MTUS Chronic Pain Medical Treatment Guidelines support the use of nonsedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Within the documentation available for review, the patient has a chronic injury and there is no documentation to support muscle spasms. The request for #60 is also not consistent with the 2-3 weeks of treatment recommended by the CA MTUS and, unfortunately, there is no provision for

modification of the current request. In light of the above issues, the currently requested Flexeril 10mg #60 is not medically necessary.

**Neurontin 300 MG, #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epileptic medication.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-21.

**Decision rationale:** Regarding request for Neurontin, CA MTUS Chronic Pain Medical Treatment Guidelines state that antiepilepsy drugs are recommended for neuropathic pain. Within the documentation available for review, there is no symptoms/findings suggestive of neuropathic pain. In the absence of such documentation, the currently requested Neurontin 300 mg # 60 is not medically necessary.

**Medrol (Pak)) 4 MG, #20:** 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), Pain Chapter, Oral Corticosteroids

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Oral Corticosteroids

**Decision rationale:** Regarding the request for MEDROL (PAK) 4 MG, #20, California MTUS does not address the issue. ODG cites that oral corticosteroids are not recommended for chronic pain, as there is no data on the efficacy and safety of systemic corticosteroids in chronic pain, so given their serious adverse effects, they should be avoided. In light of the above issues, the currently requested MEDROL (PAK) 4 MG, #20 is not medically necessary.