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| <b>Case Number:</b>   | CM14-0187913 |                              |            |
| <b>Date Assigned:</b> | 11/18/2014   | <b>Date of Injury:</b>       | 06/27/2013 |
| <b>Decision Date:</b> | 01/06/2015   | <b>UR Denial Date:</b>       | 10/29/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 11/11/2014 |

### 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 Occupational Medicine 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 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:

This individual is a 38 y/o female who has developed a chronic pain syndrome subsequent to an injury date 6/27/13. She is described to have low back pain that is reported to be VAS levels of 6-7/10. She was recently started on Butrans 5ug q 7 days, this is reported to have provided a little relief for the first 2 weeks and then this effect wore off. No functional improvements are reported. She was also started on Tylenol #3 with little temporary benefit. The requesting physician notes long-term prior knee pain that has had treatment from another physician, but there is no review of the treatment or prior testing. A recent QME report documents prior knee care, prior x-rays and a diagnosis of bilateral patellar femoral syndrome. No additional testing was recommended and the knee was considered permanent and stationary. The QME also noted a lack of prior shoulder tests and recommended x-rays and possible MRI scanning. Prior treatment included Percocet.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**X-ray Right and Left Knee per 10/21/14 form quantity 1.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 23-27.

**Decision rationale:** MTUS Guidelines recommends specific standards regarding adequate history and exam findings to justify a diagnosis, treatment and testing. These standards have not been meet. The requesting physician has not reviewed prior treatment, prior testing and the prior diagnosis. Prior to requesting repeat testing Guidelines recommend adequate medical review. The request for repeat right and left knee x-rays are not medically necessary.

**X-ray Left Shoulder, per 10/21/14 form quantity 1.00:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation ODG Shoulder, Radiography

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207.

**Decision rationale:** MTUS Guidelines support shoulder x-rays for problems that persist on a long- term basis. The reported A-C tenderness and limited Range of Motion (ROM) justify the x-ray request per Guidelines. The Left shoulder x-ray is medically necessary.

**Tylenol no.4 per 10/21/14 quantity 60.00:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 92.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Initiating therapy Page(s): 77, 78.

**Decision rationale:** When new or different opioids are being trial Guidelines allow for increasing the dose if partial analgesia is attained from a lower dose. Allowing a trial of the Tylenol #4 is consistent with Guidelines as she reports partial analgesic from a lower dose.. If there are no clear improvements in pain and function with the increased dose, this can be re-reviewed. The Tylenol #4 #60 is medically necessary.

**Butrans 10mg, per 10/21/14 form quantity 4.00:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine Page(s): 26-27.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids initiating therapy Page(s): 77, 78.

**Decision rationale:** When new or different opioids are being trial Guidelines allow for increasing the dose if partial analgesia is attained from a lower dose. Allowing a trial of the Increased Butrans is consistent with Guidelines as she reports partial analgesic from a lower dose. If there are no clear improvements in pain and function with the increased dose, this can be re-reviewed. The Butrans 10mg #4 is medically necessary.

