

<b>Case Number:</b>	CM15-0020105		
<b>Date Assigned:</b>	02/09/2015	<b>Date of Injury:</b>	01/04/2001
<b>Decision Date:</b>	04/14/2015	<b>UR Denial Date:</b>	01/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2015

### 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: New York, Pennsylvania, Washington  
 Certification(s)/Specialty: Internal Medicine, Geriatric Medicine

### 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 40-year-old male, who sustained an industrial injury on 05/03/2007. He has reported subsequent left shoulder, low back and right leg pain and was diagnosed with lumbar herniated disc, left shoulder subacromial impingement, cerebral concussion, cervical spine sprain, right wrist sprain, left shoulder injury and lumbar sprain. Treatment to date has included oral pain medication, epidural injections, H wave unit and surgery. The only medical documentation submitted is an agreed medical examination dated 04/23/2014. The injured worker reported neck, wrist and low back pain during this visit. There was no medical documentation submitted that pertains to the current treatment request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI Lumbar Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guideline (ODG).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-310.

**Decision rationale:** This injured worker had prior radiographic studies including x-rays and MRI of the lumbar spine. MRI can be useful to identify and define low back pathology in disc protrusion and spinal stenosis. However, the lumbar pathology had been delineated and documented on prior studies. In the absence of physical exam evidence of red flags, a MRI of the lumbar spine is not medically indicated. The medical necessity of a lumbar MRI is not substantiated in the records.

**Consult with Pain Management:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideline (ODG) Treatment in Workers Compensation TWC.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 7.

**Decision rationale:** This injured worker has chronic pain with an injury sustained in 2007. The worker has been treated with multiple modalities of pain management including oral pain medication, epidural injections, H wave unit and surgery. A comprehensive multidisciplinary approach to pain management is indicated for patients with more complex or refractory problems. The physical exam and radiographic findings do not support this complexity. The medical necessity of a pain management consult is not substantiated in the records.

**Meds x1 Oxycodone 30mg #100:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 74-80.

**Decision rationale:** This injured worker has chronic pain with an injury sustained in 2007. The medical course has included numerous treatment modalities including surgery. Per the guidelines, in opioid use, ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects is required. Satisfactory response to treatment may be reflected in decreased pain, increased level of function or improved quality of life. The records fail to document any significant improvement in pain, functional status or a discussion of side effects specifically related to opioids to justify use per the guidelines. Additionally, the long-term efficacy of opioids for chronic back pain is unclear but appears limited. The medical necessity of oxycodone is not substantiated in the records.