MAXIMUS Federal Services

Case Number:	CM13-0006862		
Date Assigned:	12/27/2013	Date of Injury:	06/01/2011
Decision Date:	06/05/2014	UR Denial Date:	07/05/2013
Priority:	Standard	Application Received:	08/05/2013

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. The expert reviewer is Board Certified in American Board of Orthopaedic Surgery 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:

The injured worker is a 64 year old female with an industrial related injury occurring on May 31, 2011. The mechanism of injury is described as lifting 20-25 pounds of dishware from a rack. The diagnosis is a complete rupture of the rotator cuff (727.61) to the left shoulder. Previous records indicated there are ongoing complaints of left shoulder and left upper extremity pain and numbness. A decrease in cervical spine range of motion is reported. Neer's and Hawkins test were both positive. A prior note indicates that the injured worker did not want to pursue injection therapies. Electrodiagnostic studies were obtained and a right Carpal Tunnel Syndrome is noted. There is no evidence of left carpal tunnel syndrome or a cervical radiculopathy. The September examination noted ongoing left shoulder pain and numbness of the bilateral upper extremities. The medications prescribed were noted to be Orudis and hydrocodone. A prior determination dated July 05, 2013 reflects medications Prilosec, hydrocodone, Mediderm Patch and Orudis were not certified. There was a lack of documentation for the clinical rationale for these preparations.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRILOSEC #28: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

Decision rationale: This medication is a proton pump inhibitor useful for the treatment of gastro esophageal reflux disease (GERD) and is considered a gastric protectant for individuals utilizing non-steroidal anti-inflammatory medications (in this case Orudis). There are numerous proton pump inhibitors available over the counter without a prescription. Gastritis has not been reported as a diagnosis for this claimant; however, there has not been any objective occasion on physical examination that such a malady exists. Furthermore, this preparation has been utilized for more than a year with no noted efficacy or utility in terms of resolving the complaints. Therefore, the use of this medication is not medically necessary at this time. With no clinical improvement, one does not see the clinical indication for continuing an unsuccessful preparation.

MEDIDERM PATCH #12: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111 of 127.

Decision rationale: The progress notes do not indicate that this medication has been prescribed. Furthermore, while noting diffuse upper extremity complaints there is no noted efficacy or utility. As such, there is insufficient clinical data presented to support this request.