

Case Number:	CM13-0013849		
Date Assigned:	03/10/2014	Date of Injury:	06/11/2012
Decision Date:	04/30/2014	UR Denial Date:	08/07/2013
Priority:	Standard	Application Received:	08/19/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Occupational Medicine, and is licensed to practice in New York and North Carolina. 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 Physician 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 patient, a 51 year old male, claims work injury 6/11/2012, when a sand bag rolled on top of him while he was driving an ATC. He suffered loss of consciousness and was diagnosed with a concussion. He is s/p interbody fusion L4-S1 on 2/14/13, and is now diagnosed with postlaminectomy syndrome, shoulder impingement and cervical radiculitis. He has numbness and weakness in the left lower extremity. He has shoulder pain, limiting his activities, and has been diagnosed with a rotator cuff tear.

IMR ISSUES, DECISIONS AND RATIONALES

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

STEROID INJECTION TO THE LEFT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

Decision rationale: Steroid injection into the subacromial bursa is indicated for impingement syndrome after conservative treatment 2-3 weeks. The total number of injections should be limited to three per episode, with assessment between injections. There is not the established

diagnosis of impingement, however. The orthopedic tests for impingement (negative Hawkins, drop test both noted 7/2013) are negative, according to the medical record.

ULTRAM ER 150 MG, #30 WITH 2 REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list - Tramadol, Page(s): 94.

Decision rationale: Patients not on on tramadol should be started at 100 mg per day of the long-acting preparation, not the requested 150 mg preparation. This request was for an initial prescription. Furthermore, assessment of prior medications and their effectiveness has not been documented. I support the adverse determination, and deny the request.

PERCOCET 10/325 MG, #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 88, 94.

Decision rationale: This employee was on Percocet 5/325 mg, qHs when beginning with the pain specialist. The employee used it longer than advised post-operatively and for incorrect indications - sleep. There is no clear understanding of the goal of therapy in using more Percocet daily. The criteria for chronic use have not been addressed, as described in the MTUS chronic pain guidelines, including documentation of prior treatment and effectiveness.

DICLOFENAC XR 100 MG, #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, Page(s): 67-68 and 71.

Decision rationale: Voltaren[®]-XR (diclofenac): 100 mg PO once daily for chronic therapy. Voltaren[®]-XR should only be used as chronic maintenance therapy. According to the MTUS Chronic pain guidelines, it is indicated that there is no reason to recommend one NSAID over another. NSAIDs are indicated for back pain and neuropathic pain, as well as osteoarthritis. Voltaren has an indication for "pain", up to 150 mg per day, as a divided 50 mg dose. Although diclofenac may be appropriate, the long-acting preparation is only indicated for chronic use, and its usefulness has not yet been established so that chronic treatment can be recommended.