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| Case Number: | CM14-0109624 | | |
| Date Assigned: | 08/01/2014 | Date of Injury: | 09/28/2013 |
| Decision Date: | 09/10/2014 | UR Denial Date: | 07/14/2014 |
| Priority: | Standard | Application Received: | 07/15/2014 |

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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 56 year old female was reportedly injured on September 28, 2013. The mechanism of injury was noted as a traction/pulling event. The most recent chiropractic progress note, dated March 31, 2014, indicated that there were ongoing complaints of right upper extremity pain. The physical examination demonstrated tenderness to palpation and a decreased range of motion of the right upper extremity. Diagnostic imaging studies objectified ordinary disease of life degenerative changes, multiple level disc desiccations, tendinosis of the rotator cuff, and chronic impingement syndrome demonstrated by hypertrophy acromioclavicular ligament was noted on shoulder MRI. Previous treatment includes medications, surgical intervention, postoperative rehabilitation and chiropractic care. A request was made for multiple medications and was not certified in the preauthorization process on July 14, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ibuprofen Gel, No Quantity: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page(s): 111-112 of 127.

Decision rationale: As outlined in the Medical Treatment Utilization Schedule (MTUS), there is a limited indication for topical nonsteroidal preparation. It is noted these are largely experimental, with few randomized controlled trials to determine efficacy or safety. Furthermore, when noting the progress notes presented, there is no indication of any significant improvement with this topical preparation. As such, the utility and efficacy in question is thereby eliminating the medical necessity for this medication. Therefore, this request is not medically necessary.

Tramadol (Ultram) 50mg, twice a day #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75,78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): 82, 113 of 127.

Decision rationale: As outlined in the Medical Treatment Utilization Schedule (MTUS), this medication is not recommended as a first line therapy. This is a synthetic opioid analgesic, and with the findings on physical examination and ongoing complaints, there is no objective indication that this medication has any efficacy whatsoever. Therefore, when noting the restrictions outlined in the guidelines and by the ongoing complaints of pain and physical examination findings, there was no indication of any success or reduction in pain. Thus, this request is not medically necessary.