

Case Number:	CM14-0013551		
Date Assigned:	02/26/2014	Date of Injury:	08/20/2007
Decision Date:	06/26/2014	UR Denial Date:	01/06/2014
Priority:	Standard	Application Received:	02/03/2014

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 Orthopedic 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 50-year-old individual injured in August 2007. The mechanism of injury is not specified. A right shoulder injury was noted, and with the November 2013 progress note surgical intervention was pending. The physical examination noted a decrease in shoulder range of motion. The clinical assessment was a rotator cuff tear of the right shoulder, impingement syndrome of the left shoulder with an associated lumbar radiculopathy and internal derangement of the right knee. Imaging studies noted some degenerative changes in the lumbar spine and shoulder and there were minimal electrodiagnostic findings. The January 2014 evaluation noted a borderline hypertensive individual in no acute distress. The presenting complaints are chest pain and stress-related disorder. EKG was unchanged and within normal limits. Stress management was suggested. Multiple pain management interventions are implemented. The right shoulder rotator cuff repair was completed in February 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

2 WEEKS OF HOME HEALTH CARE 4 HOURS PER DAY FOR 5 DAYS PER WEEK:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medicare Benefits Manual, Chapter 7- Home Health Services, section 50.2 (Home Health Aide Services).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

Decision rationale: The records reflect multiple degenerative situations and the most current clinical intervention was a right shoulder arthroscopy. There are no other comorbidities that would compromise the ability to function within the home. Furthermore, the necessity for such a protocol is not outlined in terms of what medical treatment is required. As per the California Medical Treatment Utilization Schedule (CAMTUS), such services should not include shopping, cleaning and laundry and personal care. Therefore, there is insufficient clinical information presented to support this request.

MEDROX PAIN RELIEF OINTMENT: Upheld

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

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

Decision rationale: Medrox ointment is a topical analgesic ointment containing Methyl Salicylate 20.00%, Menthol 5.00%, Capsaicin 0.0375%. The California Medical Treatment Utilization Schedule (CAMTUS), notes that topical analgesics are largely experimental and there have been few randomized controlled trials. Additionally, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Based on the clinical documentation provided, there is no documentation that a previous trial of oral antidepressant or anticonvulsant has been attempted. As such, the requested medication is not medically necessary and appropriate.