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| Case Number: | CM14-0015223 | | |
| Date Assigned: | 02/28/2014 | Date of Injury: | 10/11/2013 |
| Decision Date: | 06/27/2014 | UR Denial Date: | 01/15/2014 |
| Priority: | Standard | Application Received: | 02/06/2014 |

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 Mississippi. 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 note that this 53-year-old individual was injured in October 2013. A note dated January 2014 indicated the medication tramadol was prescribed. An MRI of the left shoulder was obtained and no specific pathology identified. A follow-up progress note noted ongoing complaint of left shoulder, elbow and right wrist. The December progress note indicates complaints of left shoulder and neck pain. The injured worker was described to be in no acute distress. The physical examination noted tenderness to palpation but did not identify any specific pathology. The clinical assessment was a rotator cuff syndrome and a muscle strain.

IMR ISSUES, DECISIONS AND RATIONALES

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

CERVICAL SPINE MAGNETIC RESONANCE IMAGES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

Decision rationale: As outlined in the American College of Occupational and Environmental Medicine (ACOEM) guidelines, MRI is recommended for individuals with radicular pain syndromes and progressive findings. Based on the progress of presented for review there are

diffuse complaints, there is no clinical evidence of a nerve root compromise or neurologic dysfunction. Therefore, based on the limited clinical information presented for review this is not clinically indicated.

DIAGNOSTIC ULTRASOUND BILATERAL ELBOWS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Elbow Chapter, Ultrasound, Diagnostic

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); elbow chapter; updated May 15, 2014

Decision rationale: As noted in the Official Disability Guidelines (ODG), a diagnostic ultrasound can be recommended if there is chronic elbow pain and there is a suspected entrapment neuropathy or tendon tear. The physical examination reported does not identify either malady. As such, based on the limited clinical information presented for review, there is insufficient data to support this request. The request is not medically necessary.

ORTHOSTIM4 UNIT: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); elbow chapter; updated May 15, 2014

Decision rationale: As noted in the Official Disability Guidelines (ODG), despite being studied extensively, there is limited literature support for such an intervention. As such, when noting the limited clinical information presented for review and the lack of endorsement in the literature, there is insufficient clinical evidence presented to support this request. The request is not medically necessary.

PRILOSEC 20MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs,GASTROINTESTINAL SYMPTOMS &CARDIOVASCULAR RISK,.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs,GASTROINTESTINAL SYMPTOMS &CARDIOVASCULAR RISK, Page(s): 68.

Decision rationale: This preparation is a proton pump inhibitor useful for the treatment of gastroesophageal reflux disease (GERD) and is considered a gastric protectant for individuals utilizing non-steroidal anti-inflammatory medications according to Chronic Pain Medical

Treatment Guidelines. There are numerous proton pump inhibitors available over the counter without a prescription. Gastritis has not been documented as a diagnosis for this claimant. Therefore, the use of this medication is not considered clinically indicated at this time.