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| Case Number: | CM14-0016851 | | |
| Date Assigned: | 04/11/2014 | Date of Injury: | 05/30/2012 |
| Decision Date: | 05/28/2014 | UR Denial Date: | 01/22/2014 |
| Priority: | Standard | Application Received: | 02/10/2014 |

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 & Rehabilitation and Pain Medicine and is licensed to practice in Ohio and Texas. 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 48-year-old male who reported an injury on 05/30/2012 after he lifted a heavy object, which reportedly caused injury to his left shoulder. The injured worker failed to respond to conservative treatment and ultimately underwent arthroscopic surgery for impingement syndrome in 07/2013. The injured worker had continued pain complaints and ultimately underwent left biceps tenodesis and arthroscopy in 10/2013. The injured worker was evaluated on 11/05/2013. It was documented that the injured worker was prescribed Protonix due to postsurgical stomach irritation. The injured worker's postsurgical treatment included medications and a home exercise program. The injured worker was evaluated on 01/03/2014. It was noted that the injured worker had continued shoulder pain. Physical findings included left shoulder range of motion described as 80 degrees in abduction. The injured worker's diagnosis included impingement of the left shoulder. The injured worker's treatment plan included a reduction of medications. It was noted that the injured worker had not participated in any postoperative physical therapy. The injured worker was evaluated by the requesting provider on 01/09/2014. It was documented that the injured worker complained of continued progressive left shoulder pain. Physical findings of the left shoulder included restricted range of motion described as 95 degrees in flexion, 75 degrees in abduction, 40 degrees in internal rotation, and external rotation to the L5. It was noted that the injured worker had a positive Hawkins test, positive Speed's test, and positive Yergason's test with tenderness to palpation of the acromioclavicular joint and bicipital groove and coracoid process. The diagnosis was listed as shoulder pain of the left shoulder. The injured worker's treatment plan included an MRI arthrogram of the left shoulder to rule out internal derangement, physical therapy, a refill of medications, a urine drug screen, and modified work duties.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 MRI ARTHROGRAM OF THE LEFT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: The request for 1 MRI arthrogram of the left shoulder is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends imaging studies for injured workers who need clarification of anatomy prior to surgical intervention and have had persistent symptoms and clinical indications that would benefit from surgical intervention that have failed to respond to conservative treatments. The clinical documentation indicates that the injured worker has not failed to respond to all lower levels of conservative care. The injured worker's treatment plan includes physical therapy. As the injured worker has not had any physical therapy postsurgically, the need for an imaging study is not supported. As such, the request for 1 MRI arthrogram of the left shoulder is not medically necessary or appropriate.

1 PRESCRIPTION OF PROTONIX 20MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-Steroidal Anti-Inflammatory Drugs (NSAID)'s, Gastrointestinal.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-Steroidal Anti-Inflammatory Drugs (NSAID)'s, Gastrointestinal (GI) Symptoms & Cardiovascular.

Decision rationale: The request for 1 PRESCRIPTION OF PROTONIX 20 MG #60 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the use of gastrointestinal protectants for injured workers who are at risk for developing gastrointestinal events related to medication usage. The clinical documentation submitted for review does indicate that the injured worker has been on this medication for an extended duration. However, an ongoing assessment of the injured worker's gastrointestinal system to support the effectiveness of this medication was not provided. Therefore, ongoing use is not supported. As such, the request for 1 prescription of Protonix 20 mg #60 is not medically necessary or appropriate.