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| Case Number: | CM14-0115034 | | |
| Date Assigned: | 08/04/2014 | Date of Injury: | 08/13/2012 |
| Decision Date: | 09/16/2014 | UR Denial Date: | 07/08/2014 |
| Priority: | Standard | Application Received: | 07/23/2014 |

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, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 44-year-old male who reported an injury 08/13/2012. The mechanism of injury was not provided within the medical records. The clinical note dated 05/05/2014 is handwritten and hard to decipher. The diagnoses included right shoulder rule out degeneration of superior labrum and partial detachment, right wrist rule out I.D. The injured worker reported right shoulder pain rated 3/10, and difficulty with lifting the arm. The injured worker had an MRI of the right shoulder. The unofficial MRI revealed degeneration of superior labrum, partial detachment of articular margin. The injured worker has had 24 sessions of physical therapy and 3 cortisone injections with mild relief. On physical examination the injured worker guarded the right shoulder. The injured worker had tenderness to the AC joint, bicep tendon groove and super deltoid of the right shoulder. Motor testing of the right shoulder revealed 4+ on the right with weakness. The injured worker's shoulder range of motion was flexion of 120 with pain, extension of 35 with pain. The injured worker's prior treatments included diagnostic imaging, physical therapy and medication management. The injured worker's medications included ibuprofen. The provider submitted a request for a Solar Care infrared heating system. A Request for Authorization was not submitted for review to include the date the treatment was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

60 tablets of Naproxen 550 mg. with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen Page(s): 66.

Decision rationale: The request for 60 tablets of Naproxen 550 mg. with 1 refill is not medically necessary. The CA MTUS guidelines recognize naproxen as a nonsteroidal anti-inflammatory drug (NSAID) for the relief of the signs and symptoms of osteoarthritis. The provider did not indicate a rationale for the request. In addition, the injured worker is already utilizing ibuprofen. It was not indicated why the injured worker would need another NSAID. Moreover, the request did not indicate a frequency for this medication. Therefore, the request is not medically necessary.