

Case Number:	CM14-0129238		
Date Assigned:	08/18/2014	Date of Injury:	05/24/2013
Decision Date:	09/22/2014	UR Denial Date:	07/25/2014
Priority:	Standard	Application Received:	08/13/2014

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 48 year-old individual was reportedly injured on 5/24/2013. The mechanism of injury is not listed. The most recent progress note dated 5/7/2014 indicates that there are ongoing complaints of low back, and left shoulder pain. The physical examination demonstrated left shoulder: abduction 10, positive impingement sign. Positive tenderness to palpation at the acromioclavicular (AC) joint and subacromial. Muscle strength 5/5. Cervical spine: positive tenderness to palpation over the left cervical and trapezius Ridge. Positive facet tenderness to palpation at C4-C7. Restricted range of motion. Pain with axial compression. Diagnostic imaging studies MRI arthrogram of the left shoulder dated 4/9/2014 reveals osteoarthritis the of the AC joint. Previous treatment includes medications, and conservative treatment. A request had been made for chiropractic treatment #12, Ultram ER #60, Anaprox, and Prilosec #60, and was not certified in the pre-authorization process on 7/25/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatments Quantity: 12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-60.

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): 58-59.

Decision rationale: CA MTUS guidelines support the use of manual therapy and manipulation (chiropractic care) for low back pain as an option. A trial of 6 visits over 2 weeks with the evidence of objective functional improvement, and a total of up to #18 visits over 16 weeks is supported. After review of the available medical records, there is no clinical documentation for the request of #12 visits. This exceeds the maximum visits are allowed by treatment guidelines. As such, this request is not considered medically necessary.

Ultram ER (unspecified strength) Quantity: 60: Upheld

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

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.

Decision rationale: The California MTUS guidelines support the use of Tramadol (Ultram) for short-term use after there is been evidence of failure of a first-line option, evidence of moderate to severe pain, and documentation of improvement in function with the medication. A review of the available medical records fails to document any improvement in function or pain level with the previous use of Tramadol. As such, the request is not considered medically necessary.

Anaprox (unspecified dosage/quantity) Quantity: 1: Upheld

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

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): 66, 73.

Decision rationale: Anaprox is recommended as an option. Anaprox is a nonsteroidal anti-inflammatory drug (NSAID) for the relief of the signs and symptoms of osteoarthritis. See NSAIDs (non-steroidal anti-inflammatory. Recommended as an option. Naproxen is a nonsteroidal anti-inflammatory drug (NSAID) for the relief of the signs and symptoms of osteoarthritis. After review the medical documentation provided there is no listing of dosage or quantity with this request. Therefore it is deemed not medically necessary.

Prilosec (unspecified dosage) Quantity: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs and proton-pump inhibitors.

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): 68-69.

Decision rationale: MTUS guidelines support the use of proton pump inhibitors (PPI) in patients taking non-steroidal anti-inflammatory medications with documented gastroesophageal distress symptoms and/or significant risk factors. Review of the available medical records, fails to document any signs or symptoms of gastrointestinal (GI) distress which would require PPI treatment. As such, this request is not considered medically necessary.