MAXIMUS Federal Services

Case Number:	CM14-0028484		
Date Assigned:	06/16/2014	Date of Injury:	03/07/2013
Decision Date:	08/13/2014	UR Denial Date:	02/24/2014
Priority:	Standard	Application Received:	03/06/2014

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 Physical Medicine and Rehabilitation 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 43-year-old female who reported an injury on 03/07/2013. The mechanism of injury was not provided. On 01/22/2014, the injured worker presented with moderate pain aggravated with heavy lifting and reaching and pushing activities. The range of motion was decreased to the right shoulder and there was moderate tenderness to the subacromial bursa. An MRI dated 05/31/2013 noted the right shoulder demonstrated degenerative arthrosis of the glenohumeral joint with degenerative labral tear and supraspinatus tendinitis. There were marginal osteophytes and articular cartilage thinning and eburnation of the bone. There was no evidence of a rotator cuff tear. The diagnoses were impingement syndrome of the right shoulder slowly improving, moderate degenerative disc disease of the acromioclavicular joint of the right shoulder, chondromalacia of the glenohumeral joint of the right shoulder, and chronic pain in the right shoulder. Prior treatment included medications. The provider recommended an interferential unit, Omeprazole, ibuprofen, and Lidoderm patches. The provider's rationale is not provided. The Request for Authorization Form was dated 02/11/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

INFERENTIAL UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 189.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation, page(s) 118-119 Page(s): 118-119.

Decision rationale: The request for interferential unit is not medically necessary. The California MTUS does not recommend a stim care unit or interferential unit as an isolated intervention. There is no quality evidence of effectiveness, except in conjunction with recommended treatments including return to work, exercise, and medications. They may be recommended if pain is ineffectively controlled by medications, medication intolerance, history of substance abuse, or significant pain from postoperative conditions which limits the ability to perform an exercise program/physical therapy treatment, or unresponsive to conservative measures. There is a lack of evidence in the documentation provided that would reflect diminished effectiveness of her medications, a history of substance abuse, or any postoperative conditions that would limit the injured worker's ability to perform an exercise program/physical therapy treatment. Additionally, the provider's request does not indicate the site at which the interferential unit was indicated in the request as submitted. Clarification would be needed on if the interferential unit was to be rented or purchased. As such, the request is not medically necessary.

OMEPRAZOLE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines GI Symptoms & Cardiovascular Risk, page(s) 68 Page(s): 68.

Decision rationale: The request for Omeprazole is not medically necessary. The California MTUS Guidelines recommend proton pump inhibitors for injured workers at risk for gastrointestinal events. They may be recommendation for injured workers with dyspepsia secondary to NSAID therapy or for those taking NSAID medications that are at moderate to high risk for gastrointestinal events. The included medical documentation lacked evidence of the injured worker being at moderate to high risk for gastrointestinal events. It did not appear that the injured worker had a history of peptic ulcer, GI bleed, or perforation. Additionally, the provider's request did not indicate the dose, frequency, or quantity of the request. As such, the request is not medically necessary.

IBUPROFEN: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocain patch), page(s) 57-58 Page(s): 57-58.

Decision rationale: The request for ibuprofen is not medically necessary. The California MTUS Guidelines recommend the use of NSAIDs for injured workers with osteoarthritis including knee and hip, and injured workers with acute exacerbations of chronic low back pain. The guidelines

recommend NSAIDs at the lowest dose for the shortest period in injured workers with moderate to severe pain. Acetaminophen may be considered for initial therapy for injured workers with mild to moderate pain, and in particular for those with gastrointestinal, cardiovascular, or renovascular risk factors. In injured workers with acute exacerbations of chronic low back pain, the guidelines recommend NSAIDs as an option for short term symptomatic relief. The included documentation lacks evidence of a complete and adequate assessment of the injured worker's pain level. Additionally, the provider's request does not indicate the dose, quantity, or frequency of the medication in the request as submitted. As such, the request is not medically necessary.

LIDODERM PATCHES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The request for Lidoderm patches is not medically necessary. The California MTUS states Lidoderm patches may be recommended for localized peripheral pain after there has been evidence of a trial of a first line therapy tricyclic or SNRI antidepressant or an AED such as Gabapentin or Lyrica. This is not a first line treatment and is only FDA approved for postherpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than postherpetic neuralgia. The included documentation lacked evidence that the injured worker failed a first line therapy treatment such as a tricyclic or SNRI antidepressant. Additionally, the injured worker does not have a diagnosis concurrent with the guideline recommendation of Lidoderm patches. The provider's request for Lidoderm patches does not include the dose, quantity, or frequency of the medication in the request as submitted. As such, the request is not medically necessary.