

Case Number:	CM14-0064116		
Date Assigned:	07/16/2014	Date of Injury:	06/17/2013
Decision Date:	09/15/2014	UR Denial Date:	04/18/2014
Priority:	Standard	Application Received:	05/06/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in 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 34 year old female who is reported to have sustained work related injuries on 06/17/13. On the date of injury, the injured worker was walking out of a bathroom when she twisted her right ankle and subsequently fell striking her right shoulder against the marble. The records indicate that the injured worker underwent x-rays and subsequently was returned to work with restrictions. The injured worker underwent a course of physical therapy. The injured worker underwent magnetic resonance imaging (MRI) of the right shoulder on 07/16/13 which was reported as negative and subsequently received a cortisone injection which provided her a few days of relief. The injured worker is further noted to have undergone an MRI of the right ankle which was reported as negative. The injured worker has continued complaints of neck pain, bilateral shoulder pain, low back pain and right ankle and foot pain. The injured worker has not undergone any surgeries as a result of these injuries. The injured worker is noted to have no difficulties with activities of daily living in regards to self-care. The injured worker reports that her injury and discomforts prevent her from walking more than a quarter of a mile. On physical examination she is noted to have spasm of the cervical paraspinal musculature, tenderness of the cervical spine musculature. Range of motion of the shoulders is symmetric. There was no evidence of a painful arc. Neer's and Hawkins test are reported to be positive bilaterally. Right grip strength is reduced when compared to the left. There is spasm of the lumbar paraspinal musculature and tenderness. Knee range of motion is symmetric. Lachman's sign is reported to be positive on the right. There is soft tissue swelling of the right ankle. Anterior drawer sign is positive. Lower extremity motor strength is graded as 5/5. The injured worker is opined to have bilateral shoulder impingement syndrome right greater than left, status post right ankle sprain, lumbar sprain, and cervical sprain. The record includes a utilization review determination dated 04/18/14 in which requests for extracorporeal shockwave therapy 1

time a week for 4-6 weeks, Omeprazole 20mg #30, Cyclobenzaprine 7.5mg #90 and Tramadol 150mg #30 were not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Extracorporeal Shockwave Therapy 1 time a week (4 to 6)Weeks: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disabilities Guideline.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, EWST.

Decision rationale: The submitted clinical records indicate that the injured worker sustained myofascial injuries as a result of a trip and fall. She is reported to have undergone bilateral shoulder radiographs and she has undergone magnetic resonance imaging which is reported as negative. There is no evidence of calcific tendinitis and as such, there would be no clinical indication for extracorporeal shockwave therapy. Therefore, the request is medically necessary.

Omeprazole 20mg Quantity 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Nsaids Page(s): 68-69.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Proton Pump Inhibitors.

Decision rationale: The submitted clinical records do not provide any data which indicates that the injured worker suffers from medication induced gastritis, and as such, there would be no clinical indication for this medication. Therefore, the request for Omeprazole 20mg #30 is not supported as medically necessary.

Cyclobenzaprine 7.5mg quantity 90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Nsaids Page(s): 73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

Decision rationale: The submitted clinical records indicate that the injured worker has evidence of cervical, thoracic and lumbar paraspinal muscle spasm on physical examination and as such,

this medication would be clinically indicated to treat these objective findings. Therefore, the request for Cyclobenzaprine 7.5 mg #90 is recommended as medically necessary.

Tramadol 150mg Quantity 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiates Page(s): 74-80.

Decision rationale: The submitted clinical records indicate that the injured worker sustained myofascial strains. Opiate medications are not typically provided for myofascial injuries. Further, the injured worker is greater than one year post date of injury with no evidence of urine drug screening or documentation of functional improvements to support the continued use of this medication. Therefore, the request for Tramadol 150 mg #30 is not medically necessary.