

<b>Case Number:</b>	CM14-0197919		
<b>Date Assigned:</b>	12/08/2014	<b>Date of Injury:</b>	03/12/2001
<b>Decision Date:</b>	03/03/2015	<b>UR Denial Date:</b>	11/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/25/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: New York, New Hampshire, Washington  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 patient is a 56-year-old female with date of injury of March 12, 2001. The patient has had right knee arthroscopy and lumbar laminectomy. The patient continues to have chronic pain. The patient's diagnosis cervical disc herniation. The patient is also diagnosed with lumbar spinal stenosis and right shoulder rotator cuff condition. The patient also has left knee arthritis. On physical examination she has tenderness of the neck with decreased range of motion of the neck. Right shoulder exam shows decreased range of motion. Does positive Hawkins and Neer's test. There is tenderness to the a.c. joint. At issue is whether MRI the shoulder is medically needed. Also at issue is whether multiple medications are medically needed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Kera\Tek Analgesics Gel 4%:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical anesthetics.

**Decision rationale:** MTUS guidelines indicate that any compounded medicine containing the component that is not recommended by guidelines, is therefore not recommended. This medicine contains menthol which is not recommended by guidelines. The request is not medically necessary.

**Ambien (Zolpidem Tartrate) 5mg #30:** 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.

**Decision rationale:** Ambien is not recommended per guidelines in this case. The medical records do not document that the patient has had significant problems of sleep. Guidelines do not recommend the use of sleep agents for chronic pain. The request is not medically necessary.

**Anexsia (Hydrocodone/APAP 7.5/325mg #30):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Narcotics.

**Decision rationale:** The medical records do not indicate that the patient has had significant functional improvement with previous narcotic use. MTUS guidelines do not recommend use of narcotics for chronic pain. The request is not medically necessary.

**Nexium 40mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Prilosec (Nexium).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Nexium.

**Decision rationale:** MTUS guidelines do not recommend the use of Nexium for this patient. The medical records do not document the need for GI prophylaxis. Medical records do not document previous gastrointestinal complaints or significant risk factors for gastrointestinal problems. The request is not medically necessary.

**MRI (R) Shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, MRI

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**Decision rationale:** This patient does not meet MTUS criteria for shoulder MRI. Specifically the medical records do not document that the patient has had an adequate trial and failure conservative measures to include a recent trial and failure physical therapy. The medical records do not document the results of subacromial injection. More conservative measures are needed. The request is not medically necessary.