

Case Number:	CM15-0134839		
Date Assigned:	07/23/2015	Date of Injury:	12/02/2008
Decision Date:	09/23/2015	UR Denial Date:	06/22/2015
Priority:	Standard	Application Received:	07/13/2015

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: Arizona, Michigan
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 59 year old female who sustained an industrial injury on 12/2/08. The injured worker was diagnosed as having glenohumeral arthritis status post total shoulder replacement. Currently, the injured worker was with complaints of left shoulder discomfort. Previous treatments included status post total shoulder replacement, physical therapy, injection therapy, oral pain medication, benzodiazepine, antidepressant, analgesic, non-steroidal anti-inflammatory drugs and oral pain medication. Previous diagnostic studies included radiographic studies (January 2015) revealing no radiographic abnormality of the shoulder. The injured work status was noted as disabled. The injured workers pain level was not noted. Physical examination was notable for left shoulder with tenderness to palpation, diminished range of motion however with noted improvement as compared to the prior month's examination as well as decreased pain. The plan of care was for a follow up with physician once a month for 3 months, Gabapentin 800 milligrams quantity of 120, Percocet 10/325 milligrams quantity of 45 and Mobic.

IMR ISSUES, DECISIONS AND RATIONALES

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

Follow up with physician once a month for 3 months: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207. Decision based on Non-MTUS Citation ACOEM, Occupational Medicine Practice Guidelines (2008), page 557.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207.

Decision rationale: The request is for a follow up with physician once a month for 3 months which the UR partially certified to a follow up with [REDACTED] once a month quantity of 3. The injured worker was with complaints of left shoulder discomfort. American College of Occupational and Environmental Medicine recommendations state that "Patients with shoulder complaints can have follow-up every three to five days by an appropriate health professional who can counsel them about avoiding static positions, medication use, activity modification, and other concerns. The practitioner should take care to answer questions and make these sessions interactive so that the patient is fully involved in his or her recovery." Although provider documentation dated 5/28/15 shows the injured worker is improved, the injured worker is still having diminished range of motion and tenderness to palpation of the left shoulder upon physical examination. As such, the request for a follow up with physician once a month for 3 months is medically unnecessary.

Gabapentin 800mg, quantity of 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 49.

Decision rationale: The request is for Gabapentin 800 milligrams quantity of 120. The injured worker was with complaints of left shoulder discomfort. CA MTUS recommendations state that Gabapentin is effective in treatment of diabetic painful neuropathy and post herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The clinical documentation submitted for review failed to provide documentation of the injured workers functional response to the medication and as such, failed to indicate the its efficacy. As such, the request for Gabapentin 800 milligrams quantity of 120 is not medically unnecessary.

Percocet 10/325mg, #45: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use-Therapeutic Trial of Opioids; Opioids for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80.

Decision rationale: The request is for Percocet 10/325 milligrams quantity of 45. The injured worker was with complaints of left shoulder discomfort. CA MTUS discourages long term

usage unless there is evidence of "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts.

Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. CA MTUS Guideline Citation: Title 8, California Code of Regulations, et seq. Effective July 18, 2009 pg. 1 indicates "Functional improvement" is evidenced by a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management. There is a lack of functional improvement with the treatment already provided. The treating physician did not provide sufficient evidence of improvement in the work status, activities of daily living, and dependency on continued medical care. Provider documentation dated 5/28/15 noted the plan was to discontinue Percocet. In addition, there is no documentation of pain assessments. As such, the request for Percocet 10/325 milligrams quantity of 45 is not medically unnecessary.

Mobic: 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 NSAIDS Page(s): 67-73.

Decision rationale: The request is for Mobic which the UR modified to Mobic 1 month supply. The injured worker was with complaints of left shoulder discomfort. CA MTUS recommends the lowest dose NSAID for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors." CA MTUS recommends NSAIDs as a second-line treatment after acetaminophen and as a short term option. Provider documentation submitted does not offer an explanation as to why an over the counter NSAID was not utilized initially. Provider documentation shows the injured worker has been prescribed Mobic since 4/30/15. As such, the request for Mobic is medically unnecessary and therefore the request for Mobic is not medically necessary.