

Case Number:	CM15-0149451		
Date Assigned:	08/12/2015	Date of Injury:	09/30/1997
Decision Date:	09/18/2015	UR Denial Date:	07/18/2015
Priority:	Standard	Application Received:	07/31/2015

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: California

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:

This is a 70 year old female with a September 30, 1997 date of injury. A progress note dated July 1, 2015 documents subjective complaints (increased pain in the feet rated at a level of 7 out of 10; decreased pain in the bilateral wrists rated at a level of 6 out of 10; increased pain in the neck rated at a level of 7 out of 10; pain without medications rated at a level of 8 to 9 out of 10), objective findings (antalgic gait; maximum tenderness of the right shoulder; decreased range of motion of the cervical spine; painful sacroiliac joints; thoracic spasm; decreased range of motion of the lumbar spine; significant tenderness with palpation of the anterior lateral, and posterior shoulder; tenderness to palpation of the left plantar foot and ball of foot; decreased arch support), and current diagnoses (foot pain; cervical radiculitis; shoulder pain; plantar facial fibromatosis; Achilles bursitis or tendinitis). Treatments to date have included medications, acupuncture, chiropractic treatments, epidural steroid injection, and facet joint injections, heat, ice, massage therapy, occipital nerve block, and physical therapy. The medical record indicates that medications help control the pain. There is no updated neurological exam of the upper extremities and no detailing of upper extremity numbness. There is no detailed exam of the shoulder other than diffuse tenderness. There is a history of peptic ulcer disease. The treating physician documented a plan of care that included Cymbalta 50mg #30 with 5 refills, Protonix 40mg #30 with 5 refills, electromyogram-nerve conduction velocity study of the bilateral upper extremities, a right shoulder subacromial bursa injection, and Percocet 5-325mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cymbalta 50mg #30 with 5 refills: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants for Pain Page(s): 15.

Decision rationale: MTUS Guidelines support the use of Cymbalta for chronic pain with a neuropathic component. This individual is described to have a component of neuropathic pain and is reported to obtain significant pain relief and functional improvement with the medication. In these circumstances, the Cymbalta 50mg. #30 with 5 refills is supported by Guidelines and is medically necessary.

Protonix 40mg #30 with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs and GI distress Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain/Proton Pump Inhibitors.

Decision rationale: Guidelines support the use of first line proton pump inhibitors for GI distress associated with medication use. This individual is documented to have a history of peptic ulcer disease that is assumed to be medical need for proton pump inhibitors. However, Guidelines (ODG) notes that common 1st line proton pump inhibitors are just as effective as 2nd line inhibitors (Protonix) and 2nd line inhibitors should not be utilized unless there are problems with 1st line medications. There is no evidence of prior trials of 1st line medications such as Zantac. Under these circumstances, the Protonix 40mg #30 with 5 refills is not supported by Guidelines and is not medically necessary.

EMG/NCV bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 178 and 261.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 23/257/261.

Decision rationale: MTUS Guidelines have minimum standards for medical evaluations to justify diagnostic testing. These standards have not been met. There is no neurological exam of the upper extremities which would support the medical necessity of this testing. There is no measure loss of sensation, strength, or reflexes. Without a minimal neurological exam / evaluation the medical necessity of the EMG/NCV bilateral upper extremities is not supported by Guidelines and is not medically necessary. There are no unusual circumstances to justify an exception to Guidelines and therefore is not medically necessary.

Right Shoulder Subacromial Bursa Injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Shoulder (Acute & Chronic), Steroid Injections.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 9 Shoulder Complaints Page(s): 23/200-204.

Decision rationale: MTUS Guidelines have minimal standards of medical evaluation to support diagnostic testing or invasive procedures. This standard has not been met. The documentation notes diffuse shoulder tenderness to touch, but no other standard diagnostic maneuvers are reported to evaluate for subacromial bursitis/rotator cuff syndrome. Without an adequate evaluation the request for a subacromial injection is not supported by Guidelines and there are no unusual circumstances to justify an exception to Guidelines. At this point in time the subacromial bursa injection is not medically necessary.

Percocet 5/325mg #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80.

Decision rationale: MTUS Guidelines support the careful use of Opioids when there is the triad of meaningful pain relief, support of function and a lack of drug related behaviors. This individual meets these Guidelines. Significant pain relief is reported, detailed functional improvements are documented and there is no evidence of misuse during limited use over a long period of time. Under these circumstances, the Percocet 5/325mg #60 is supported by Guidelines and is medically necessary.