

Case Number:	CM15-0200831		
Date Assigned:	10/15/2015	Date of Injury:	11/10/1995
Decision Date:	11/24/2015	UR Denial Date:	09/29/2015
Priority:	Standard	Application Received:	10/13/2015

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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 60 year old male, who sustained an industrial-work injury on 11-10-95. A review of the medical records indicates that the injured worker is undergoing treatment for joint derangement of bilateral shoulders, lumbosacral neuritis, brachial neuritis, chronic pain syndrome, and history of diabetes. Treatment to date has included pain medication, Percocet, Oxycodone, Ambien, Gabapentin since at least 4-3-15, physical therapy, injections, bracing, rest and other modalities. Medical records dated 8-12-15 and 9-23-15 indicate that the injured worker is overall feeling the same. He reports right shoulder pain, left side pain that goes to the foot and headaches. The pain is rated 9-10 out of 10 on the pain scale on average with 10 percent relief of pain with medications. The activities of daily living (ADL) and overall functioning have remained the same per the medical records. Per the treating physician report dated 9-23-15 the injured worker has not returned to work. The physical exam dated 9-23-15 were unchanged from the previous exam and reveals that the bilateral shoulder exam shows positive spring back arm test with weakness of the shoulder muscles. There was tenderness over the left sacroiliac joint and lumbar spine. The physician indicates that a left sacroiliac joint injection was given at the appointment. The treating physician indicates that the urine drug test result dated 6-17-15 was inconsistent with the medication prescribed. The request for authorization date was 9-23-15 and requested services included 1 Cortisone Injection Bilateral Shoulder and 1 Prescription of Gabapentin 600mg, #180. The original Utilization review dated 9-29-15 non-certified the request for 1 Cortisone Injection Bilateral Shoulder and 1 Prescription of Gabapentin 600mg, #180.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Cortisone Injection Bilateral Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, (Acute, & Chronic) Steroid Injections.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder- Steroid injections.

Decision rationale: 1 cortisone injection bilateral shoulder is not medically necessary per the MTUS Guidelines and the ODG. The MTUS states that conservative care, including cortisone injections, can be carried out for at least three to six months before considering surgery. The ODG states that cortisone injections can be attempted with a diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems, except for post-traumatic impingement of the shoulder. The documentation submitted does not reveal a clear diagnosis of the above conditions therefore this request is not medically necessary.

1 Prescription of Gabapentin 600mg, #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: 1 Prescription of Gabapentin 600mg, #180 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that after initiation of antiepileptics such as Neurontin treatment there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The documentation indicates that the patient has been on Gabapentin without any significant evidence of increased function or significant pain relief on the documentation submitted. Therefore the request for continued Gabapentin is not medically necessary.