

Case Number:	CM15-0043767		
Date Assigned:	03/13/2015	Date of Injury:	03/09/2011
Decision Date:	05/01/2015	UR Denial Date:	02/04/2015
Priority:	Standard	Application Received:	03/09/2015

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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 50-year-old female who reported an injury on 03/09/2011. The mechanism of injury was repetitive use. The diagnoses include persistent bilateral shoulder tendinopathy with left shoulder impingement, left cubital tunnel syndrome, right thoracic outlet syndrome, and a history of a cubital tunnel release on 07/09/2014 and a right shoulder subacromial decompression in 11/2012. Prior therapies included physical therapy. The injured worker was noted to undergo urine toxicology screens. The injured worker's medications included Flexeril 7.5 mg, Protonix, and Motrin since at least 09/2014. The injured worker underwent post-op physical therapy. There was a Request for Authorization submitted for review dated 01/23/2015. The documentation of 01/23/2015 revealed minimal tenderness on the right cubital tunnel with moderate tenderness on the left cubital tunnel. The left shoulder impingement sign was positive. There was tenderness in the shoulders with some crepitation, more on the left versus right. The supraclavicular compression test was mildly positive. The injured worker was noted to have pain precluded a restful sleep. The diagnosis included persistent bilateral shoulder tendinopathy with left impingement. The treatment plan included physical therapy 2 times a week x3 weeks for the shoulders and thoracic outlet, Motrin 600 mg #90, Lunesta 1 mg at bedtime when necessary, Tylenol No. 3 one 3 times a day as needed #60, Protonix 20 mg 1 tablet twice a day due to a history of nontolerance to NSAIDs with history of gastritis and to prevent gastric ulceration given the need for NSAID medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motrin #600mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67, 68, 72.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines indicate that NSAIDS are recommended for short-term symptomatic relief of low back pain. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual injured worker treatment goals. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review indicated the injured worker had utilized the medication for an extensive duration of time. There was a lack of documentation of objective functional improvement and an objective decrease in pain. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Motrin 600 mg #90 is not medically necessary.

Lunesta 1mg, #30: 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), Mental illness & stress.

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, Lunesta.

Decision rationale: The Official Disability Guidelines indicates the use of Lunesta is for the short-term treatment of insomnia, generally 2 - 3 weeks. The documentation indicated that the injured worker's pain precluded a restful sleep. The clinical documentation submitted for review failed to provide documentation of exceptional factors, as this medication is not recommended for more than 3 weeks. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Lunesta 1 mg #30 is not medically necessary.

Tylenol # 300/30mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Analgesic Page(s): 80-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend opiates for the treatment of chronic pain. The clinical documentation submitted for review indicated this medication had been prescribed and the injured worker had achieved activities of daily living on the medication. However, there was a lack of documentation indicating objective functional improvement and an objective decrease in pain. There was documentation the injured worker was being monitored for aberrant drug behavior and side effects. The request as submitted failed to indicate the frequency for the requested medication. Additionally, the request as written is incorrect, as there is no strength that is Tylenol #300/30. This was not a determining factor in the denial. Given the above, the request for Tylenol #300/30 mg #60 is not medically necessary.

Protonix 20mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend PPIs for the treatment of dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review indicated the injured worker had dyspepsia secondary to NSAID therapy. However, the efficacy of the medication was not provided. Additionally, as this review was concurrently reviewing for the NSAID and the NSAID was found to be not medically necessary, this request would not be supported. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Protonix 20 mg #60 is not medically necessary.