

Case Number:	CM15-0058184		
Date Assigned:	04/02/2015	Date of Injury:	10/27/2004
Decision Date:	06/11/2015	UR Denial Date:	03/13/2015
Priority:	Standard	Application Received:	03/26/2015

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, Public Health & General Preventive 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 54 year old female, who sustained an industrial injury on 10/27/2004. The injured worker is currently diagnosed as having residuals left shoulder after prior surgery, left shoulder impingement, right shoulder impingement, and right shoulder partial thickness rotator cuff tear. Treatment to date has included physical therapy, chiropractic treatment, cervical spine MRI, cervical spine fusion, epidural injection, and medications. In a progress note dated 10/13/2014, the injured worker presented with complaints of left shoulder pain and also increased right shoulder pain due to overcompensating. The injured worker had completed a course of physical therapy for the left shoulder and would be starting acupuncture. Upon examination of the cervical spine, there was decreased range of motion, positive muscle spasm, and positive Spurling's test. There was decreased range of motion on flexion and abduction of the left shoulder with positive Neer's and Hawkins's test. Treatment recommendations at that time included continuation of the current medication regimen. There was no Request for Authorization form submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Menthoderm Ointment (Unspecified dosage): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. In this case, there was no documentation of a failure of first line oral medication. The request as submitted failed to indicate the strength, frequency, or quantity. Given the above, the request is not medically necessary.

Omeprazole (Unspecified dosage & quantity): 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 Page(s): 68-69.

Decision rationale: California MTUS Guidelines state, proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. In this case, there was no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. The medical necessity for the requested medication has not been established. Additionally, there is no frequency, strength, or quantity listed in the request. As such, the request is not medically appropriate.

Naproxen (Unspecified dosage & quantity): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: The California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second line option after acetaminophen. In this case, there was no documentation of objective functional improvement despite the ongoing use of this medication. Guidelines do not support long term use of NSAIDs. In addition, the request as submitted failed to indicate the strength, frequency, or quantity. Given the above, the request is not medically necessary.

MRI of Bilateral Shoulders: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) TWC Shoulder Procedures.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: California MTUS/ACOEM Guidelines state for most patients with shoulder problems, special studies are not needed unless a 4 to 6 week period of conservative care and observation fails to improve symptoms. There was no documentation of a significant functional deficit upon examination. There was no documentation of a comprehensive physical examination of the right shoulder. The medical necessity for an MRI of the bilateral shoulders has not been established in this case. As such, the request is not medically necessary.