

Case Number:	CM14-0129737		
Date Assigned:	08/20/2014	Date of Injury:	11/05/1998
Decision Date:	10/07/2014	UR Denial Date:	07/23/2014
Priority:	Standard	Application Received:	08/14/2014

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 male who sustained an injury on 11/05/98. No specific mechanism of injury was noted. Prior treatment for the injured worker included multiple epidural steroid injections without substantial relief. The injured worker continued reporting complaints of low back pain radiating to the left lower extremity and neck pain radiating to the right upper extremity. The injured worker was followed for concurrent depression and anxiety secondary to chronic pain. The injured worker had gastric upset with medication regimen specifically anti-inflammatory that was intermittent. The last evaluation for the injured worker was from 05/21/14. Clinical record noted the injured worker was receiving some benefit with the use of opioids with pain scores reduced by 30%. The injured worker was able to perform some activities of daily living with medications. Physical examination at this visit noted limited range of motion of both the neck and low back with positive straight leg raise to the left at 70 degrees. Spurling's sign was mildly positive to the right. There was loss of range of motion in the right shoulder. The injured worker was pending right shoulder surgical intervention at this visit. No other clinical records were available for review. The requested medications including Norco, Morphine, Diclofenac, Zanaflex, Zoloflex, Zanaflex, Prilosec, Lunesta, aquatic therapy and OrthoStim stimulator were denied by utilization review on 07/23/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #90 between 7/3/2014 and 9/14/2014: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, Page(s): 88-89.

Decision rationale: In review of the requested service it is the opinion that medical necessity has not been established. The injured worker was pending right shoulder surgical intervention as of May of 2014. There were no further clinical evaluations for this injured worker establishing the need for the requested service at this time. Given the paucity of clinical information after May of 2014 establishing the need for the request this reviewer would not have recommended the proposed service as medically necessary.

12 sessions of water Aerobics between 7/3/2014 and 9/14/2014: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22.

Decision rationale: In review of the requested service it is the opinion that medical necessity has not been established. The injured worker was pending right shoulder surgical intervention as of May of 2014. There were no further clinical evaluations for this injured worker establishing the need for the requested service at this time. Given the paucity of clinical information after May of 2014 establishing the need for the request this reviewer would not have recommended the proposed service as medically necessary.

Morphine IR 15mg #40 between 7/3/2014 and 9/14/2014: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, Page(s): 88-89.

Decision rationale: In review of the requested service it is the opinion that medical necessity has not been established. The injured worker was pending right shoulder surgical intervention as of May of 2014. There were no further clinical evaluations for this injured worker establishing the need for the requested service at this time. Given the paucity of clinical information after May of 2014 establishing the need for the request this reviewer would not have recommended the proposed service as medically necessary.

Diclofenac 100mg between 7/3/2014 and 9/14/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's (non-steroidal anti-inflammatory).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68.

Decision rationale: In review of the requested service it is the opinion that medical necessity has not been established. The injured worker was pending right shoulder surgical intervention as of May of 2014. There were no further clinical evaluations for this injured worker establishing the need for the requested service at this time. Given the paucity of clinical information after May of 2014 establishing the need for the request this reviewer would not have recommended the proposed service as medically necessary.

Zanaflex 2mg, #30 between 7/3/2014 and 9/14/2014: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-67.

Decision rationale: In review of the requested service it is the opinion that medical necessity has not been established. The injured worker was pending right shoulder surgical intervention as of May of 2014. There were no further clinical evaluations for this injured worker establishing the need for the requested service at this time. Given the paucity of clinical information after May of 2014 establishing the need for the request this reviewer would not have recommended the proposed service as medically necessary.

Zoloft 50mg between 7/3/2014 and 9/14/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines)Antidepressants

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants, Page(s): 13-16.

Decision rationale: In review of the requested service it is the opinion that medical necessity has not been established. The injured worker was pending right shoulder surgical intervention as of May of 2014. There were no further clinical evaluations for this injured worker establishing the need for the requested service at this time. Given the paucity of clinical information after May of 2014 establishing the need for the request this reviewer would not have recommended the proposed service as medically necessary.

Xanax 0.25mg #60 between 7/3/2014 and 9/14/2014: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: In review of the requested service it is the opinion that medical necessity has not been established. The injured worker was pending right shoulder surgical intervention as of May of 2014. There were no further clinical evaluations for this injured worker establishing the need for the requested service at this time. Given the paucity of clinical information after May of 2014 establishing the need for the request this reviewer would not have recommended the proposed service as medically necessary.

Prilosec 20mg #60 between 7/3/2014 and 9/14/2014: Upheld

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

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, proton pump inhibitors

Decision rationale: In review of the requested service it is the opinion that medical necessity has not been established. The injured worker was pending right shoulder surgical intervention as of May of 2014. There were no further clinical evaluations for this injured worker establishing the need for the requested service at this time. Given the paucity of clinical information after May of 2014 establishing the need for the request this reviewer would not have recommended the proposed service as medically necessary.

Lunesta 3mg #40 between 7/3/2014 and 9/14/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines) Insomnia treatment

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, Insomnia Treatment

Decision rationale: In review of the requested service it is the opinion that medical necessity has not been established. The injured worker was pending right shoulder surgical intervention as of May of 2014. There were no further clinical evaluations for this injured worker establishing the need for the requested service at this time. Given the paucity of clinical information after May of 2014 establishing the need for the request this reviewer would not have recommended the proposed service as medically necessary.

1 Orthostim IV muscle stimulator between 7/3/2014 and 9/14/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (ICS) Interferential current stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 113-117.

Decision rationale: In review of the requested service it is the opinion that medical necessity has not been established. The injured worker was pending right shoulder surgical intervention as of May of 2014. There were no further clinical evaluations for this injured worker establishing the need for the requested service at this time. Given the paucity of clinical information after May of 2014 establishing the need for the request this reviewer would not have recommended the proposed service as medically necessary.