

Case Number:	CM14-0212977		
Date Assigned:	12/30/2014	Date of Injury:	06/05/2014
Decision Date:	02/27/2015	UR Denial Date:	11/21/2014
Priority:	Standard	Application Received:	12/19/2014

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. 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: Physical Medicine & Rehabn

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 patient is a 48-year-old female with date of injury of 06/05/2014. The listed diagnoses from 10/20/2014 are: 1. Right C6-C7 radiculopathy. 2. Right AC joint degenerative joint disease. 3. Right shoulder impingement sign versus rotator cuff tear. According to this report, the patient complains of ongoing neck pain, which radiates down the right bicep extending to the arm, which she rates a 7/10 with medication and 8/19 without medication. Her current list of medication includes Anaprox, Imitrex, Protonix, and Ultram. Examination shows decreased sensation over the right C5, C6, C7, and C8. Radial pulses are palpable bilaterally. Examination of the shoulders revealed a normal contour. There is no evidence of appreciable swelling over the bilateral shoulders. There is palpable tenderness over the right AC joint and right aspect of the shoulder. Sensory examination of the upper extremities is intact. Positive impingement sign on the right and a positive cross-arm test on the right. Range of motion is diminished on the right shoulder. Treatment reports from 10/20/2014 were provided for review. The utilization review denied the request on 11/21/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pennsaid Ointment-sample- retro review for date of service 11/4/14: Upheld

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

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

Decision rationale: This patient presents with neck pain, which radiates down the right bicep extending to the forearm, and right shoulder pain. The treater is requesting PENNSAID OINTMENTSAMPLESRETRO REVIEW FOR DATE OF SERVICE 11/04/2014. The MTUS Guidelines page 111 states for topical analgesics, Largely experimental in use with few randomized control trials to determine efficacy or safety, primarily recommended for neuropathic pain, when trials of antidepressants and anti-convulsants have failed. MTUS further states that for topical NSAIDs, it has been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis. It is indicated for the knee and elbow or joints that are amenable to topical treatment and is recommended for short-term use (4 to 12 weeks). The records do not show a history of Pennsaid use. The treater does not discuss what this ointment is to be used for. However, it would appear that the treater is prescribing this medication for the patients neck and shoulder. Pennsaid is not recommended for the spine, hip, or shoulder. The request IS NOT medically necessary.

Right subacromial steroid injection and right corticosteroid injection over right AC joint for diagnostic purposes: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder chapter on steroid injections

Decision rationale: This patient presents with neck pain, which radiates down the right bicep extending to the forearm, and right shoulder pain. The treater is requesting RIGHT SUBACROMIAL STEROID INJECTION AND RIGHT CORTICOSTEROID INJECTION OVER RIGHT AC JOINT FOR DIAGNOSTIC PURPOSES. The ACOEM guidelines page 213 states, two or three subacromial injections of local anesthetic and cortisone preparation over an extended period as a part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome, or small tears. Diagnostic lidocaine injection to distinguish pain sources in the shoulder area (e.g., impingement). ODGs criteria for steroid injection includes a diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems; not controlled adequately by recommended conservative treatments; pain interferes with functional activities, etc. The 10/20/2014 report notes that the patient had a prior right shoulder injection, which provided significant relief of pain. In this case, the patient does have a diagnosis of right shoulder impingement, and the request is supported by the guidelines. The request IS medically necessary.

