

Case Number:	CM15-0002248		
Date Assigned:	01/13/2015	Date of Injury:	01/30/2004
Decision Date:	03/13/2015	UR Denial Date:	12/24/2014
Priority:	Standard	Application Received:	01/06/2015

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, New York, Florida

Certification(s)/Specialty: Internal Medicine, Pulmonary Disease, Critical Care 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 42-year-old female who reported an injury on 01/30/2004. The mechanism of injury was not stated. The current diagnoses include cervical discopathy with radiculitis, bilateral cubital tunnel syndrome, right medial epicondylitis, status post right cubital tunnel release, status post right shoulder arthroscopic surgery on 01/08/2010, left shoulder internal derangement, and right wrist pain. The injured worker presented on 11/21/2014 with complaints of 7/10 neck pain with radiation in the upper extremities, as well as increasing, constant pain in the right shoulder rated 8/10 with activity limitation. Upon examination of the cervical spine, there was palpable paravertebral muscle tenderness with spasm, positive axial loading compression test, positive Spurling's maneuver, limited range of motion with pain, tingling and numbness into the anterolateral shoulder and arm, and normal motor strength. Upon examination of the right shoulder, there was tenderness around the anterolateral aspect, pain with terminal motion, limited range of motion and weakness, and a well healed right shoulder scar. Recommendations at that time included continuation of the current medication regimen and an ergonomic work station evaluation. There was no Request for Authorization submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI (R) Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208.

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

Decision rationale: California MTUS/ACOEM Practice Guidelines state for most patients presenting with true shoulder problems, special studies are not needed unless a 4 to 6 week period of conservative care and observation fails to improve symptoms. In this case, there was no documentation of a recent attempt at any conservative treatment. There was no evidence of any red flags for serious pathology. There was no physiologic evidence of tissue insult or neurovascular dysfunction. Given the above, the request is not medically appropriate at this time.

Ergonomic workstation Eval/Adjustment: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state a number of functional assessment tools are available when reassessing function and functional recovery. The injured worker presented with complaints of severe neck and right shoulder pain. There is no mention of an attempt at any recent conservative treatment. There is no indication that this injured worker has reached or is close to reaching maximum medical improvement. The medical necessity for an ergonomic work station evaluation/adjustment has not been established in this case. As such, the request is not medically appropriate.

Fenoprofen Calcium (Nalfon) 400mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67.

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

Decision rationale: California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose of 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. It is unclear how long the injured worker has utilized Nalfon 400 mg. The California MTUS Guidelines do not recommend long term use of NSAIDs. There is also no frequency listed in the request. Given the above, the request is not medically appropriate.

Omeprazole 20mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: The 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. There was no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the injured worker does not meet criteria for the requested medication. There is also no frequency listed in the request. As such, the request is not medically appropriate.

Cyclobenzaprine Hydrochloride tablets 7.5mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as nonsedating second line options for short term treatment of acute exacerbations. It is unclear how long the injured worker has utilized cyclobenzaprine 7.5 mg. California MTUS Guidelines do not recommend long term use of muscle relaxants. There is also no frequency listed in the request. Therefore, the request is not medically appropriate.

Eszopiclone 1mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, supports a hypnotic medications for short-term (2-6 weeks) treatment of insomnia

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Insomnia Treatment.

Decision rationale: The Official Disability Guidelines recommend insomnia treatment based on ideology. Lunesta has demonstrated reduced sleep latency and sleep maintenance. There is no mention of a failure to respond to nonpharmacologic treatment prior to the initiation of a prescription product. The injured worker does not maintain a diagnosis of insomnia disorder.

The medical necessity for the requested medication has not been established in this case. There is also no frequency listed in the request. As such, the request is not medically appropriate.