

Case Number:	CM14-0003085		
Date Assigned:	01/31/2014	Date of Injury:	01/15/2011
Decision Date:	08/04/2014	UR Denial Date:	12/17/2013
Priority:	Standard	Application Received:	01/08/2014

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 Physical Medicine & Rehabilitation 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 patient is a 56-year-old male who has filed a claim for shoulder impingement associated with an industrial injury date of January 15, 2011. Review of progress notes indicates worsening of right shoulder pain, and development of left shoulder pain. Findings include asymmetric shoulders, painful clicking of the right shoulder upon elevation, tenderness of the rotator cuff tendons, decreased range of motion, and decreased muscle strength. Patient reports difficulty sleeping due to pain. Right shoulder MRI dated March 21, 2013 showed distal supraspinatus tendon repair with intact rotator cuff, and chronic tear of the tendon of the long head of the biceps. Ultrasound of the right shoulder dated June 13, 2013 showed no tendinosis or tear of the rotator cuff. Left shoulder MRI from October 2013 showed mild tendinosis of the supraspinatus. Treatment to date has included NSAIDs, opioids, muscle relaxants, zolpidem, Zofran, betamethasone dipropionate, Flector patches, trigger point injections, physical therapy, home exercises, and right shoulder surgeries on October 14, 2011 and June 08, 2012. Utilization review from December 17, 2013 denied the request for Alprazolam 1mg daily and zolpidem tartrate 10mg daily as these are not recommended for long-term use; ketorolac tromethamine 10mg every 4 hours as the oral form is only recommended for 5-day use, and there is a higher risk of developing further GI issues with this medication; diclofenac sodium 75mg 2 times per day as this is not recommended as a first-line medication due to increased risk profile; Zofran 4mg every 8 hours as this is not recommended for nausea and vomiting secondary to chronic opioid use; and betamethasone dipropionate 0.05% daily as there was no indication provided for use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Alprazolam (1mg daily): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: As noted in the Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. Patient has been on this medication since January 2013. There is no recent description of the patient's anxiety symptoms. In addition, this medication is not recommended for long-term use. The requested quantity is not specified. Therefore, the request is not medically necessary.

Zolpidem Tartrate (10mg daily): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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, Ambien (zolpidem tartrate).

Decision rationale: The California MTUS Guidelines do not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines (ODG) was used instead. According to the ODG, Ambien is approved for the short-term (usually two to six weeks) treatment of insomnia. There is also concern that they may increase pain and depression over the long-term. The patient has been on this medication since January 2012. There is no recent description of patient's sleep difficulties, or of continued benefits with this medication. In addition, this medication is not recommended for long-term use. The requested quantity is not specified. Therefore, the request for zolpidem tartrate 10mg daily was not medically necessary.

Ketorolac Tromethamine (10mg every 4 hours): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (nonsteroidal anti-inflammatory drugs) Page(s): 67-69, 72.

Decision rationale: As stated in the Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and there is no evidence of long-term effectiveness for pain or function. Ketorolac is not indicated for minor or chronic painful conditions. Patient has been on this medication since October 2012. This medication is recommended only for acute treatment of severe pain, which the patient does not currently have. The requested quantity is not specified. Therefore, the request is not medically necessary.

Diclofenac Sodium (75mg - 2 times per day): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (nonsteroidal anti-inflammatory drugs) Page(s): 67-69.

Decision rationale: As stated in the Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and there is no evidence of long-term effectiveness for pain or function. Patient has been on this medication since July 2013. The requested quantity is not specified. There is no documentation regarding symptomatic improvement or objective functional benefits derived from this medication. In addition, this patient has gastrointestinal symptoms and Barrett's esophagus, and continuation of this medication is not necessary as the patient is already on opioid therapy. Therefore, the request is not medically necessary.

Zofran (4mg every 8 hours): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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, Antiemetics (for opioid nausea).

Decision rationale: The California MTUS Guidelines do not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines (ODG) was used instead. According to ODG, ondansetron is recommended for nausea and vomiting secondary to chemotherapy, radiation, and post-operative use. Acute use is FDA-approved for gastroenteritis. It is not recommended for nausea and vomiting secondary to chronic opioid use. The patient has been on this medication since July 2013. There is no documentation regarding nausea or vomiting in this patient. The requested quantity is not specified. Therefore, the request is not medically necessary.

Betamethasone Dipropionate (0.05% daily): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation FDA (Betamethasone).

Decision rationale: The California MTUS Guidelines do not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the FDA was used instead. According to the FDA, betamethasone dipropionate lotion 0.05% is a medium-potency corticosteroid indicated for the relief of inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses for patients 13 years and older. The patient has been prescribed this medication in July 2013. There is no rationale provided for the use of this medication. The patient does not complain of dermatologic conditions at this time. Therefore, the request is not medically necessary.