

Case Number:	CM14-0007420		
Date Assigned:	02/07/2014	Date of Injury:	11/01/2011
Decision Date:	07/24/2014	UR Denial Date:	01/07/2014
Priority:	Standard	Application Received:	01/16/2014

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 Occupational 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 patient is 53-year-old female who has submitted a claim for post arthroscopy with rotator cuff repair of the bilateral shoulders, lumbar and cervical disc degeneration, lumbar and cervical radiculopathy, and chronic pain associated from an industrial injury date of November 1, 2011. Medical records from 2012-2014 were reviewed, the latest of which dated January 30, 2014 which revealed that the patient continues to have weakness and pain in the bilateral shoulders. She is doing physical therapy at home, which continues to be very beneficial for her. Her cervical spine as well as her lower back continues to be symptomatic and painful. On physical examination, there are well-healed arthroscopic portals in the bilateral shoulders. There is limitation in range of motion of the left shoulder with forward flexion and adduction to approximately 155 degrees. Internal rotation to the SI joint and manual muscle testing is 4/5. There is limitation in range of motion of the right shoulder with forward flexion and adduction to approximately 150 degrees. Internal rotation to the SI joint and manual muscle testing is 4/5. Treatment to date has included left shoulder arthroscopy with rotator cuff repair (10/5/12), right shoulder arthroscopy with rotator cuff repair (2/15/13), physical therapy, home exercise program, and medications that include Ambien, Norco and Soma. Utilization review from January 7, 2014 denied the request for PHYSICAL THERAPY TWELVE (12) SESSIONS FOR THE BILATERAL SHOULDERS because the most recent clinical evaluation does not indicate exceptional factors or deficits that require supervised therapy as opposed to rehabilitation in a fully independent home exercise program; denied the request for NORCO 10/325MG, #60 because the current medical records still do not include documentation of quantifiable pain relief, functional improvement, appropriate medication use, lack of aberrant behaviors and lack of intolerable side effects; and denied the request for AMBIEN 10MG, #60 because the most recent

documentation does not provide a rationale from the treating provider as to why guideline recommendations should not be followed for this patient.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY TWELVE (12) SESSIONS FOR THE BILATERAL SHOULDERS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99, Postsurgical Treatment Guidelines Page(s): 27.

Decision rationale: As stated on page 99 of the CA MTUS Chronic Pain Medical Treatment Guidelines, physical medicine allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home exercise. In addition, the Post-Surgical Treatment Guidelines recommends postsurgical physical therapy for 40 visits over 16 weeks within the treatment period of 6 months. In this case, patient underwent left shoulder arthroscopy with rotator cuff repair (10/5/12) and right shoulder arthroscopy with rotator cuff repair (2/15/13). The patient had postsurgical physical therapy; however, the total number of physical therapy sessions received is unknown due to lack of documentation. Furthermore, pain relief and functional improvements were not documented. Also, the extension of therapy will exceed the guideline recommendation treatment period of 6 months. Therefore, the request for PHYSICAL THERAPY TWELVE (12) SESSIONS FOR THE BILATERAL SHOULDERS is not medically necessary.

NORCO 10/325MG, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR THE USE OF OPIOIDS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-81.

Decision rationale: According to pages 78-81 of the CA MTUS Chronic Pain Medical Treatment Guidelines, ongoing opioid treatment is not supported unless prescribed at the lowest possible dose and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In this case, patient has been on Norco since January 2014 for pain. The most recent clinical evaluation revealed no analgesia and functional improvement with its use. Also, there is no discussion regarding the side effects or possible aberrant behavior with opioid use. The medical necessity of Norco was not established. Therefore, the request for NORCO 10/325MG, #60 is not medically necessary.

AMBIEN 10MG, #60: Upheld

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

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to 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. In this case, the patient has been on Ambien since January 2014. The most recent clinical evaluation does not document subjective or objective finding that support the diagnosis of insomnia. There was no discussion concerning the patient's sleep hygiene. Moreover, the extension of treatment will exceed the guideline recommendation period of 2-6 weeks. The medical necessity of Ambien was not established. Therefore, the request for AMBIEN 10MG, #60 is not medically necessary.