

<b>Case Number:</b>	CM14-0009732		
<b>Date Assigned:</b>	06/04/2014	<b>Date of Injury:</b>	01/19/2010
<b>Decision Date:</b>	08/05/2014	<b>UR Denial Date:</b>	01/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/23/2014

### 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, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 34-year-old female who reported an injury on 01/19/2010. The mechanism of injury was the injured worker passed out and fell due to stress from the store manager. The injured worker underwent urine drug screens. The injured worker's medication history included Ambien 10 mg, Soma 350 mg, and oxycodone as of 08/2013. The documentation of 09/09/2013 indicated the injured worker had complaints of frequent headaches. Diagnoses included headache, brachial neuritis or radiculitis, thoracic sprain/strain, lumbar radiculopathy, left shoulder sprain/strain, and stress. The treatment plan included medication management with a urine drug screen, extracorporeal shockwave lithotripsy, and an ultrasound of the lumbar spine, as well as Oxycodone 10 mg #90, Ambien 10 mg #30, and Soma 250 mg.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **OXYCODONE 10MG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain and Ongoing Management Page(s): 60, 78.

**Decision rationale:** The California MTUS Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication for greater than 1 month. There was a lack of documentation indicating the injured worker had an objective decrease in pain and documentation the injured worker had an objective increase in function. The request as submitted failed to indicate the quantity and frequency for the requested medication. Given the above, the request for oxycodone 10 mg is not medically necessary.

**AMBIEN 10MG:** Upheld

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

**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 Official Disability Guidelines indicate that Ambien is recommended for the short-term treatment of insomnia. The duration of use should not exceed 6 weeks. The clinical documentation submitted for review indicated the injured worker had utilized the medication for greater than 1 month. There was a lack of documented efficacy. The request as submitted failed to indicate the frequency and quantity of medication being requested. Given the above, the request for Ambien 10 mg is not medically necessary.

**SOMA 350MG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CARISOPRODOL (SOMA) Page(s): 29.

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

**Decision rationale:** The California MTUS Guidelines recommend muscle relaxants as a second-line option for the short-term treatment of acute low back pain, and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review indicated the injured worker had utilized the medication for greater than 1 month. There was a lack of documented efficacy. The request as submitted failed to indicate the frequency and the quantity of the medication being requested. The clinical documentation also indicated the injured worker was utilizing cyclobenzaprine as a muscle relaxant as well. There was a lack of documentation indicating a necessity for two muscle relaxants. Given the above, the request for Soma 350 mg is not medically necessary.

**LUMBAR ULTRASOUND:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Ultrasound, Diagnostic.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Ultrasound, Diagnostic.

**Decision rationale:** The Official Disability Guidelines indicate that a diagnostic ultrasound is not recommended for the diagnosis of low back conditions. The clinical documentation submitted for review failed to indicate a documented rationale for the requested lumbar ultrasound. Given the above, the request for a lumbar ultrasound is not medically necessary.

**EXTRACORPOREAL SHOCKWAVE LITHOTRIPSY:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Extracorporeal Shock Wave Therapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Wang, Ching-Jen. Extracorporeal shockwave therapy in musculoskeletal disorders. Journal of Orthopaedic Surgery and Research 7.1 (2012): 1-8.

**Decision rationale:** Per Wang, Ching-Jen (2012), The application of extracorporeal shockwave therapy (ESWT) in musculoskeletal disorders has been around for more than a decade and is primarily used in the treatment of sports related over-use tendinopathies such as proximal plantar fasciitis of the heel, lateral epicondylitis of the elbow, calcific or non-calcific tendonitis of the shoulder and patellar tendinopathy etc. The clinical documentation submitted for review failed to provide documentation of the quantity of treatments. The request as submitted failed to indicate the body part to be treated. Given the above, the request for extracorporeal shockwave lithotripsy is not medically necessary.