MAXIMUS Federal Services

Case Number:	CM14-0156656		
Date Assigned:	09/26/2014	Date of Injury:	05/08/2013
Decision Date:	10/29/2014	UR Denial Date:	08/28/2014
Priority:	Standard	Application Received:	09/24/2014

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 Orthopedic Surgery 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:

This is a 40-year-old female claimant with reported industrial injury of May 8, 2013. Progress note dated August 18th, 2014 demonstrates complaints of right shoulder pain. Report states that patient has been treated conservatively by a chiropractor. Current complaints include shoulder pain radiating to her neck. Exam note August 18, 2014, demonstrates full shoulder range of motion. There is tenderness noted over the glenohumeral joint. Tenderness is noted also over the acromioclavicular joint and biceps tendon. The prior utilization review from 8/27/14 notes the treating provider is requesting one postoperative visit with x-ray Right shoulder MRI on August 4, 2014 demonstrates moderate rotator cuff tendinosis, mild acromioclavicular arthrosis, and discoid like morphology of superior labrum without tear.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zolpidem 5 MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines Zolpidem (Ambien).

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

Decision rationale: The MTUS/ACOEM is silent on the issue of Ambien. According to the ODG, Pain Section, Zolpidem (Ambien) is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. There is no evidence in the records from 8/18/14 of insomnia to warrant Ambien. Therefore, Zolpidem 5 MG #30 is not medically necessary and appropriate.

Zofran 8 MG #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines Pain Chapter Anti Emetics.

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

Decision rationale: The MTUS/ACOEM is silent on the issue of Zofran for postoperative use. According to the ODG, Pain Chapter, Ondansetron (Zofran) is not recommended for nausea and vomiting secondary to chronic opioid use. In this case the submitted records demonstrate no evidence of nausea and vomiting or increased risk for postoperative issues. Therefore, Zofran 8 MG #10 is not medically necessary.

Norco 10/325 MG #60 0 Refill: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80.

Decision rationale: According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 80, opioids should be continued if the patient has returned to work and the patient has improved functioning and pain. The exam note from 8/18/14 demonstrates there is insufficient evidence to support use of narcotics. There is no evidence of demonstrated functional improvement, percentage of relief, demonstration of urine toxicology compliance or increase in activity. Therefore Norco 10/325 MG #60 0 Refill is not medically necessary.

Naproxen 550 MG #60 0 Refill: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment.

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

Decision rationale: Per the MTUS/Chronic Pain Medical Treatment Guidelines, page 66 states that Naproxen is a non-steroidal anti-inflammatory drug (NSAID) for the relief of the signs and symptoms of osteoarthritis. It is used as first line treatment but long-term use is not warranted. The records from 8/18/14 do not demonstrate evidence of osteoarthritis, nor does the MRI of the shoulder from August 4th 2014. Therefore, Naproxen 550 MG #60 0 Refill is not medically necessary.

Four Post Operative Appointments within Global Period with Fluoroscopy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Shoulder Chapter Office VIsits

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

Decision rationale: The MTUS/ACOEM is silent on the issue of office visits. According to the ODG, Shoulder section, office visits, it is recommended as determined to be medically necessary. The prior utilization review from 8/27/14 notes the treating provider is requesting one postoperative visit with x-ray. Therefore, Four Post Operative Appointments within Global Period with Fluoroscopy are not medically necessary.

Two Week Game Rental: 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) Shoulder, Cryotherapy

Decision rationale: CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow crytotherapy, it is recommended immediately postoperatively for upwards of 7 days. In this case the request exceeds the 7 day recommendation. Therefore the determination is for non-certification.