

Case Number:	CM14-0096374		
Date Assigned:	09/15/2014	Date of Injury:	09/20/2010
Decision Date:	10/30/2014	UR Denial Date:	05/22/2014
Priority:	Standard	Application Received:	06/19/2014

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 Anesthesiologist, Pain Medicine and is licensed to practice in Florida. 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 35-year-old male with a reported injury on 09/20/2010. The mechanism of injury was pulling and pushing repetitively. The injured worker's diagnoses included right shoulder pain and anxiety disorder. The injured worker's previous treatments included physical therapy, a sling, and medications. The injured worker's diagnostic testing was not provided. The injured worker's surgical history included a right shoulder arthroscopic acromioplasty, repair of superolateral tear from anterior to posterior, Mumford, and debridement. On 04/16/2014, the injured worker had an arthroscopic repair of the right superolateral tear from anterior to posterior and debridement. The injured worker was evaluated postoperatively on 04/30/2014. He complained of pain to his right shoulder surgery rated 9/10 in severity. He was participating in physical therapy. The clinician observed and reported that the injured worker was wearing his sling. A bandage was in place over the right shoulder with no strike through bleeding. The rest of the examination was unchanged. The injured worker was evaluated on 01/07/2014 where the clinician reported tenderness on the anterior and lateral of the right shoulder on palpatory examination. The injured worker's medications included Norco 10/325 mg, Ambien, Robaxin, Cymbalta, and Biofreeze topical roll on gel. These medications are unchanged from 12/12/2013. The requests are for retro Ambien 10 mg #60, retro Norco 10/325 mg (quantity unspecified), retro Tylenol #15 (mg unspecified). The rationale for this request was not provided. The Request for Authorization form was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro 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

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

Decision rationale: The request for Retro Ambien 10mg #60 is not medically necessary. The injured worker did not have any sleep complaints. The Official Disability Guidelines recommend short term (usually 2 to 6 weeks) use of Ambien for treatment of insomnia. While sleeping pills, so called minor tranquilizers and antianxiety 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. The injured worker has been receiving Ambien since at least 12/12/2013 which exceeds the recommended guidelines for use. Additionally, the request did not include frequency of dosing. Therefore, the request for Retro Ambien 10mg #60 is not medically necessary.

Retro Norco 10/325mg (QTY Unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91, 78-80, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-79.

Decision rationale: The decision for Retro Norco 10/325mg (QTY Unspecified) is not medically necessary. The injured worker rated his postsurgical pain as 9/10. The California MTUS Chronic Pain Guidelines recommend discontinuation of opioids if there is no overall improvement in function, unless there are extenuating circumstances. No date was listed on the request and no Request for Authorization form was submitted so it is unclear which date the prescription would be retroactive for. However, the injured worker had been prescribed Norco since at least 12/12/2013 but the documentation provided in the last 3 visits on 03/05/2014, 04/02/2014, and 04/30/2014 did not indicate a decrease in pain with the use of the Norco 10/325 mg. The provided documentation did not indicate any increase in function related to the use of Norco 10/325mg. Additionally, the request did not include a frequency of dosing. Therefore, the request for Retro Norco 10/325mg (QTY Unspecified) is not medically necessary.

Retro Tylenol #15 (MG Unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 92.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Acetaminophen Page(s): 11-12.

Decision rationale: The request for Retro Tylenol #15 (MG Unspecified) is not medically necessary. The injured worker continued to complain of right shoulder pain. The California MTUS Chronic Pain Guidelines recommend acetaminophen for the treatment of chronic pain and acute exacerbations of chronic pain, specifically for osteoarthritis and chronic low back pain. The documentation provided did not indicate a prescription for acetaminophen or Tylenol. The request did not include a date for the retro decision, strength of the medication, or a frequency of dosing. Therefore, the request for Retro Tylenol #15 (MG Unspecified) is not medically necessary.