

Case Number:	CM14-0199203		
Date Assigned:	12/09/2014	Date of Injury:	05/16/2008
Decision Date:	01/22/2015	UR Denial Date:	11/20/2014
Priority:	Standard	Application Received:	11/26/2014

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 Preventive 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:

According to the records made available for review, this is a 64-year-old male with a 5/16/08 date of injury. At the time (12/3/14) of request for authorization for 1 bilateral shoulder steroid injection, 1 prescription of Ambien 10mg #20 with 1 refill, 1 prescription of Valium 10mg #15 , and 1 prescription of Oxycodone HCL 15mg #90 with 1 refill, there is documentation of subjective (right shoulder pain and poor quality of sleep) and objective (tenderness over cervical paravertebral muscle with spasm, decreased cervical as well right shoulder range of motion, and tenderness over rhomboid as well as trapezius muscles) findings, current diagnoses (shoulder and cervical pain), and treatment to date (previous shoulder steroid injection and medications (including ongoing treatment with Valium since at least 2/26/14, Oxycontin, Ambien since at least 2/26/14, and Oxycodone). Medical report identifies that previous injection to shoulder provided 100% pain relief for 3-4 months; Ambien helps to prevent sleep disturbances due to pain, able to be well rested, allowing the patient to be more active with daily living; Valium has reduced muscle spasms by 50%; pain agreement was briefly reviewed with the patient; and that Oxycodone helps relieve breakthrough pain and to stay active. Regarding 1 bilateral shoulder steroid injection, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of previous steroid injection. Regarding 1 prescription of Ambien 10mg #20 with 1 refill, there is no documentation of insomnia; short-term (two to six weeks) treatment; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Ambien use to date. Regarding 1 prescription of Valium 10mg #15, there is no documentation of the intention for short term treatment (4 weeks); and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a

result of Valium use to date. Regarding 1 prescription of Oxycodone HCL 15mg #90 with 1 refill, there is no documentation of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Oxycodone use to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 bilateral shoulder steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Steroid Injections; Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: The MTUS reference to ACOEM Guidelines identifies that shoulder injection is recommended as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement, or small tears, and that partial thickness tears can be treated the same as impingement syndrome. The MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. The ODG identify documentation of Diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems, except for post-traumatic impingement of the shoulder; failure of conservative treatments (physical therapy and exercise, NSAIDs or acetaminophen), after at least 3 months; pain interferes with functional activities (e.g., pain with elevation is significantly limiting work); and that only one injection should be scheduled to start, rather than a series of three as criteria necessary to support the medical necessity of Shoulder steroid injection. In addition, the guidelines identify that steroid injections are generally performed without fluoroscopic or ultrasound guidance. Within the medical information available for review, there is documentation of diagnoses of shoulder and cervical pain. In addition, there is documentation of previous shoulder steroid injection. However, despite documentation that previous injection to shoulder provided 100% pain relief for 3-4 months, there is no (clear) documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of previous steroid injection. Therefore, based on guidelines and a review of the evidence, the request for 1 bilateral shoulder steroid injection is not medically necessary.

1 prescription of Ambien 10mg #20 with 1 refill: 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 (Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Zolpidem; Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: The MTUS does not address this issue. The ODG identifies Ambien (Zolpidem) as a prescription short-acting non Benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. The MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of shoulder and cervical pain. However, despite of poor quality of sleep, there is no (clear) documentation of insomnia. In addition, given documentation of records reflecting prescriptions for Ambien since at least 2/26/14, there is no documentation of short-term (two to six weeks) treatment. Furthermore, despite documentation that Ambien helps to prevent sleep disturbances due to pain, able to be well rested, allowing the patient to be more active with daily living, there is no (clear) documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Ambien use to date. Therefore, based on guidelines and a review of the evidence, the request for 1 prescription of Ambien 10mg #20 with 1 refill is not medically necessary.

1 prescription of Valium 10mg #15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines identifies that benzodiazepines are not recommended for long-term and that most guidelines limit use to 4 weeks. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of shoulder and cervical pain. However, given documentation of records reflecting prescriptions for Valium since at least 2/26/14, there is no documentation of the intention for short term treatment (4 weeks). In addition, despite documentation that Valium has reduced muscle spasms by 50%, there is no (clear) documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Valium use to date. Therefore, based on guidelines and a review of the evidence, the request for 1 prescription of Valium 10mg #15 is not medically necessary.

1 prescription of Oxycodone HCL 15mg #90 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids; Oxycodone Page(s): 74-80; 92. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time, as criteria necessary to support the medical necessity of Oxycodone. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of Oxycodone. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of shoulder and cervical pain. In addition, given documentation that the pain agreement was briefly reviewed with the patient, there is documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. However, despite documentation of pain, there is no (clear) documentation of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time. In addition, despite documentation that Oxycodone helps relieve breakthrough pain and to stay active, there is no (clear) documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Oxycodone use to date. Therefore, based on guidelines and a review of the evidence, the request for 1 prescription of Oxycodone HCL 15mg #90 with 1 refill is not medically necessary.