

<b>Case Number:</b>	CM15-0106172		
<b>Date Assigned:</b>	06/26/2015	<b>Date of Injury:</b>	03/18/2009
<b>Decision Date:</b>	08/19/2015	<b>UR Denial Date:</b>	05/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/02/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Arizona, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 46 year old male who sustained an industrial injury on 03/18/2009. Current diagnoses include pain in joint of shoulder, arthropathy, shoulder bursae and tendon disorders, and shoulder region disorders. Previous treatments included medications, physical therapy, shoulder injections, TENS unit, cognitive behavioral therapy, right shoulder surgery on 01/22/2010 and 12/23/2010, and home exercise program. Previous diagnostic studies include x-rays and MRI's. Initial injuries included the right shoulder after feeling immediate pain while trying to restrain a patient. Report dated 05/01/2015 noted that the injured worker presented with complaints that included right shoulder pain with radiation to the neck and poor sleep quality. Pain level was 8 out of 10 on a visual analog scale (VAS). Current medication regimen includes Zofran, Lidoderm patches, cyclobenzaprine, Norco, and Ambien Physical examination was positive for restricted movements in the right shoulder limited by pain, decreased right shoulder strength and sensation. The treatment plan included refilled Norco and Ambien, continue ice, heat, exercise, and medications, request for a orthopedic second opinion consultation and a therapeutic massage cane. The physician noted that the request for the second opinion for the right shoulder was due to ongoing pain and decrease in function. The injured worker is temporarily totally disabled. MRI of the right shoulder shows osteoarthritis of the right shoulder and SLAP tear. Disputed treatments include consult for second opinion, therapeutic massage cane, Norco 10/325mg, and Ambien 5mg.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Consult for Second Opinion: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, 2nd Edition, page 127: Consultation.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

**Decision rationale:** ACOEM guidelines indicates that a surgical consultation may be appropriate for an injured worker who has a red flag condition, activity limitation for more than 4 months plus existence of a surgical lesion, failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs plus existence of a surgical lesion, and clear clinical and imaging evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. The documentation submitted indicated that the injured worker has tried conservative treatments which included physical therapy, injections, TENS unit, cognitive behavioral therapy, and home exercise program. The injured worker has under gone right shoulder surgery twice on 01/22/2010 and 12/23/2010. Physical examination was positive for restricted range of motion, decreased strength and sensation. MRI was positive for a SLAP tear. Therefore the request for consult for second opinion is medically necessary.

**Therapeutic Massage Cane: 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), online treatment guidelines.

**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 - Lumbar & Thoracic (Acute & Chronic) / Massage.

**Decision rationale:** The MTUS did not specifically address the use of massage devices therefore other guidelines were consulted. Per the ODG, massage is "recommended as an option in conjunction with recommended exercise programs. Manual massage administered by professional providers has shown some proven efficacy in the treatment of acute low back symptoms, based on quality studies. Mechanical massage devices are not recommended." Unfortunately the guidelines do not support medically unsupervised massage therapy, massage therapy needs to be administered by professional providers to be supported by the guidelines, therefore based on the guidelines, the request for Therapeutic Massage Cane is not medically necessary.

**Norco 10/325mg: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-going Management.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for the use of opioids, Opioids-long-term assessment, Opioids specific drug list-Hydrocodone/Acetaminophen Page(s): 74, 76-82, 88-90, and 91.

**Decision rationale:** According to the California MTUS chronic pain medical treatment guidelines recommend specific guidelines for the ongoing use of narcotic pain medication to treat chronic pain. Recommendations include the lowest possible dose be used as well as ongoing review and documentation of pain relief, functional status, appropriate medication use and its side effects. It is also recommends that providers of opiate medication document the injured worker's response to pain medication including the duration of symptomatic relief, functional improvements, and the level of pain relief with the medications. The medical records submitted for review did not include duration of symptomatic relief, functional improvements, and the level of pain relief with the medications. Therefore the request for Norco 10/325mg is not medically necessary.

**Ambien 5mg (quantity unspecified):** 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): 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 (Chronic), Zolpidem (Ambien).

**Decision rationale:** The California MTUS does not address Ambien. The Official Disability Guidelines (ODG) state that Ambien (zolpidem) is approved for short term use, usually 2-6 weeks, treatment of insomnia, and should be used for only a short period of time. The medical records submitted supports that the injured worker has been using Ambien long-term without documentation of quantifiable improvement in sleep. The ODG states that Ambien should be used for only a short period of time. Therefore the request for Ambien is not medically necessary.