

Case Number:	CM15-0198958		
Date Assigned:	10/14/2015	Date of Injury:	02/13/2015
Decision Date:	12/23/2015	UR Denial Date:	09/22/2015
Priority:	Standard	Application Received:	10/09/2015

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, Texas
 Certification(s)/Specialty: Internal 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 53 year old male who sustained an industrial injury on 02-13-2015. A review of the medical records indicated that the injured worker is undergoing treatment for lumbar sprain and strain, lumbar radiculopathy, bilateral shoulder bursitis and impingement syndrome and right lateral epicondylitis. According to the treating physician's progress report on 08-17-2015, the injured worker continues to experience mid and low back pain radiating to the left lower extremity associated with tingling rated at 6 out of 10 on the pain scale, intermittent right shoulder pain rated at 4-5 out of 10, intermittent left shoulder pain rated at 4 out of 10 and moderate right elbow pain. Examination of the lumbar spine demonstrated tenderness to palpation and spasm of the lumbar paravertebral muscles with decreased range of motion on flexion and extension. Straight leg raise was positive on the left and Patrick's Fabere was negative. Motor strength was 5 minus out of 5 bilaterally in the lower extremities. Deep tendon reflexes were within normal limits. The injured worker was noted to have a mild limp and mild antalgic gait. The bilateral lateral shoulders were tender to palpation with spasm documented on the right. Decreased flexion, extension, abduction, adduction and external rotation were noted bilaterally. Neer's and Hawkin's tests were positive bilaterally and shoulder apprehension test was negative bilaterally. Right elbow had full range of motion with tenderness to palpation of the lateral elbow and negative valgus and Tinel's signs. Right shoulder magnetic resonance imaging (MRI) performed on 03-17-2015 and electrodiagnostic studies of the lower extremities on 04-02- 2015 with official reports were included in the review. According to the interpreted review by the physician on 08-17-2015, the Electromyography (EMG) Nerve Conduction Velocity (NCV) of the lower extremities showed normal findings. Prior treatments have included

diagnostic testing, extracorporeal shockwave therapy right elbow (3 sessions), physical therapy, acupuncture therapy (4 sessions), chiropractic therapy (20 visits), steroid injections, lumbar support and medications. Current medications were listed as Norco, Ambien and topical creams. Urine drug screening collected on 05-28-2015 was inconsistent with prescribed medications and not addressed. Treatment plan consists of pain management consultation for lumbar epidural steroid injection, additional physical therapy for the bilateral shoulder and lumbar spine and the current request for Ambien 10mg #30, Norco 10mg-325mg #90, extracorporeal shockwave therapy times 6 sessions and trial one month use of transcutaneous electrical nerve stimulation (TENS) unit at home. On 09-22-2015 the Utilization Review determined the requests for Ambien 10mg #30, Norco 10mg-325mg #90, extracorporeal shockwave therapy times 6 sessions and one month use of transcutaneous electrical nerve stimulation (TENS) unit were not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 10mg #30: 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), Mental Illness & Stress: Zolpidem (Ambien) (2015); ODG, Pain (Chronic): Insomnia treatment (2015).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation UptoDate.com.

Decision rationale: The MTUS is silent regarding the use of Ambien for chronic insomnia. The FDA has approved the use of Ambien for short-term treatment of insomnia (with difficulty of sleep onset). Ambien is not approved for the long-term treatment of insomnia. When treating insomnia all patients should receive therapy for any medical condition, psychiatric illness, substance abuse or sleep disorder that may be precipitating or exacerbating the insomnia. For patients who continue to have insomnia that is severe enough to require intervention cognitive behavioral therapy (CBT) is the initial therapy that is recommended. If a patient requires a combination of behavioral therapy and medication, a short acting medication is recommended for 6-8 weeks and then tapered. If the patient is still having symptoms, they may require evaluation in a sleep disorder center prior to the institution of long-term medications. In this case the documentation doesn't support that the patient has received optimal therapy for medical and psychiatric conditions or that non-pharmacologic treatment for insomnia has failed. The use of a sleeping agent is not medically necessary.

6 extracorporeal shockwave therapy sessions: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back - Lumbar & Thoracic (Acute & Chronic): Shock wave therapy (2015).

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

Decision rationale: The MTUS is silent regarding the use of shockwave therapy for the treatment of low back pain. According to the MTUS, the available evidence does not support the effectiveness of ultrasound or shockwave for treating low back pain. The use of shockwave therapy in the treatment of low back pain is not medically necessary.

Norco 10/325 #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: The MTUS is silent regarding the use of Ambien for chronic insomnia. The FDA has approved the use of Ambien for short-term treatment of insomnia (with difficulty of sleep onset). Ambien is not approved for the long-term treatment of insomnia. When treating insomnia all patients should receive therapy for any medical condition, psychiatric illness, substance abuse or sleep disorder that may be precipitating or exacerbating the insomnia. For patients who continue to have insomnia that is severe enough to require intervention cognitive behavioral therapy (CBT) is the initial therapy that is recommended. If a patient requires a combination of behavioral therapy and medication, a short acting medication is recommended for 6-8 weeks and then tapered. If the patient is still having symptoms, they may require evaluation in a sleep disorder center prior to the institution of long-term medications. In this case the documentation doesn't support that the patient has received optimal therapy for medical and psychiatric conditions or that non-pharmacologic treatment for insomnia has failed. The use of a sleeping agent is not medically necessary.

One month use of a transcutaneous electrical nerve stimulation (TENS) unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Electrical stimulators (E-stim).

Decision rationale: According to the MTUS, the use of a transcutaneous electrical nerve stimulation (TENS) is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. These conditions include neuropathic pain, Phantom limb pain and CRPSII, spasticity, and multiple sclerosis. In this case, the patient is not enrolled in an evidence-based functional restoration program and doesn't have an accepted diagnosis per the MTUS. Therefore, the request is not medically necessary.