

Case Number:	CM15-0054818		
Date Assigned:	03/30/2015	Date of Injury:	04/11/2000
Decision Date:	05/01/2015	UR Denial Date:	02/26/2015
Priority:	Standard	Application Received:	03/23/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 69 year old, female patient, who sustained an industrial injury on 02/26/2000. The provided documentation showed evidence dated back to April 11/2013 that described subjective complaint of "not doing well", with an exacerbation of her back pain accompanied by radiation to the left leg. She has been adhering to prescribed medications with some temporary relief of symptom. Diagnoses applied for this time period listed cervical herniated nucleus pulposus, coccyx fracture, compensatory consequence of right knee injury, bilateral knee patellofemoral arthrosis, grade I spondylolisthesis at L4-5 and obesity. The most recent medical records provided were dated 01/29/2015, which showed a primary treating office visit and the patient with subjective complaint of ongoing right shoulder pain that is described as anterior, lateral pain with use of arms. The pain specifically happens with above head arm raising and has reported little relief from a Torodal injection administered at last visit. The following diagnoses are applied: right shoulder impingement syndrome, grade I spondylolisthesis at L4-5, bilateral knee patellofemoral arthrosis, coccyx fracture, compensatory consequence of right knee injury, cervical herniated nucleus pulposus and obesity. The plan of care involved continuing to recommend physical therapy treating right shoulder. If no response from therapy then recommend a steroid injection. Lastly, if no response to any of the above then recommends a magnetic resonance imaging of right shoulder ruling out a tear. She is provided prescription for Voltaren gel and Ambien; follow up in two months. Of note, pending authorization for physical therapy Diagnostic radiography noted performed on 11/25/2014 of right shoulder. Treatment has included oral medications, injections, radiography, topical

analgesia, physical therapy sessions, and aquatic therapy. Notes indicate that the patient has occasional "difficulty sleeping secondary to pain." A utilization review determination dated October 10, 2014 recommend certification of Ambien, Voltaren gel, and Norco. A progress report dated August 21, 2014 states that the patient notes significant functional improvement and pain relief with Voltaren gel and that she is unable to tolerate oral anti-inflammatories.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy, 12 sessions right shoulder 3x4: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 200. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Physical Therapy.

Decision rationale: Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no indication that the patient has undergone physical therapy for the shoulder previously. Guidelines support the use of a 6-visit trial of physical therapy. Unfortunately, the currently requested 12 visits exceed the number recommended by guidelines as a trial and, unfortunately, there is no provision for modification of the current request. In the absence of such documentation, the current request for physical therapy is not medically necessary.

Voltaren refill gel, dispense 5 pack with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics, NSAIDs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 ? 9792.26 MTUS (Effective July 18, 2009) Page(s): 111-112 of 127.

Decision rationale: Regarding the request for Voltaren gel, guidelines state that topical NSAIDs are recommended for short-term use. Oral NSAIDs contain significantly more guideline support, provided there are no contraindications to the use of oral NSAIDs. Within the documentation available for review, there is no indication that the patient has obtained any specific analgesic effect (in terms of percent reduction in pain, or reduced NRS) or specific objective functional improvement from the use of Voltaren gel. Additionally, although notes indicate that the patient is unable to tolerate oral NSAIDs, it is unclear exactly what oral NSAIDs have been tried.

Additionally, it is unclear if G.I. prophylactic medication has been tried alongside oral NSAIDs. Furthermore, the guidelines do not support the use of topical NSAIDs for long-term use. In the absence of clarity regarding those issues, the currently requested Voltaren gel is not medically necessary.

Ambien 10 mg #15 with 2 refills: 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), pain chapter, insomnia treatment.

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, Sleep Medication, Insomnia treatment.

Decision rationale: Regarding the request for zolpidem (Ambien), California MTUS guidelines are silent regarding the use of sedative hypnotic agents. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there is no current description of the patient's insomnia, no discussion regarding what behavioral treatments have been attempted, and no statement indicating how the patient has responded to Ambien treatment. Furthermore, there is no indication that Ambien is being used for short-term use as recommended by guidelines. In the absence of such documentation, the currently requested zolpidem (Ambien) is not medically necessary.