MAXIMUS Federal Services

Case Number:	CM15-0058254		
Date Assigned:	04/03/2015	Date of Injury:	09/18/2012
Decision Date:	05/12/2015	UR Denial Date:	03/25/2015
Priority:	Standard	Application Received:	03/26/2015

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: North Carolina
Certification(s)/Specialty: Family Practice

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 59 year old male, who sustained an industrial injury on 9/18/12. He reported initial complaints of right shoulder and wrist injury. The injured worker was diagnosed as having right AC joint sprain/strain; right rotator cuff lent; right shoulder bursitis; right shoulder impingement syndrome; right shoulder sprain/strain; left shoulder sprain/strain; right wrist sprain/strain; right wrist tenosynovitis; left wrist sprain/strain; left wrist tenosynovitis. Treatment to date has included MRI right shoulder and right wrist (12/21/12); right shoulder and right wrist cortisone injections; physical therapy; EMG/NCV right upper extremity (10/2/14); MRI left shoulder and wrist (1/26/15); urine drug screening; medications. Currently, the PR-2 notes dated 3/16/15 indicate the injured worker has multiple complaints: right shoulder constant achy pain; left shoulder constant moderate achy pain; right wrist constant achy pain; left wrist constant moderate achy pain. The recent MRI of left shoulder reports worsening mechanical painful symptoms and left wrist were reviewed but no comment. Notes submitted go back to 8/18/14 that prescribed Norco 5/325mg #90 TID as one prescription with one refill at that time. The provider does not document a pain scale or score for this injured worker's current pain and there is no documented objective function benefit. The provider has requested Extracorporeal Shockwave Therapy Left Shoulder and Norco 10/325mg quantity #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Extracorporeal Shockwave Therapy Left Shoulder: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, shockwave therapy.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested service. Per the Official Disability Guidelines section on shockwave therapy: Not recommended, particularly using high energy ESWT. It is under study for low energy ESWT. The value, if any, for ESWT treatment of the elbow cannot be confirmed or excluded. Criteria for use of ESWT include: 1. Pain in the lateral elbow despite six months of therapy 2. Three conservative therapies prior to ESWT have been tried prior 3. No contraindications to therapy 4. Maximum of 3 therapy sessions over 3 weeks. The patient has had pain for greater than 6 months and has failed at least 3 conservative therapy options. However the request does not specify the amount of sessions or time frame for treatment and the recommendations only are for 3 sessions maximum. Also indications are not for the shoulder. Therefore without this information, the request cannot be medically necessary, as it does not meet all criteria.

Norco 10/325 MG Qty 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 76-84.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these

controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain dairy that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to non-opioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids (a) If the patient has returned to work (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox- AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. The patient reports a decrease in pain form a 7/10 to a 5/10 with medication. However, there are no objective measures of improvement of function. Therefore, criteria for the ongoing use of o pioids have not been met and the request is not medically necessary.