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| <b>Case Number:</b>   | CM15-0077429 |                              |            |
| <b>Date Assigned:</b> | 04/29/2015   | <b>Date of Injury:</b>       | 06/15/2009 |
| <b>Decision Date:</b> | 08/19/2015   | <b>UR Denial Date:</b>       | 04/01/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 04/23/2015 |

### 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: Emergency 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 39 year old male who sustained an industrial injury on 6/15/09 involving his right shoulder while participating in a baton training exercise and wearing a padded suit. He was given medication, diagnosed with a strain and underwent physical therapy. He returned to modified duty and a few months later had an MRI of the right shoulder. He had an arthrogram, subacromial injection without benefit. He was then diagnosed with a partial rotator cuff tear and impingement and had arthroscopic surgery 7/10. After the surgery he was 100% worse with almost no range of motion, numbness and burning and was told he had a frozen shoulder. His complex regional pain syndrome severely limits his hygiene and overall functional status (per note 12/26/14). Medications are hydromorphone, Fossamax, Zofran, mexiletine. Diagnoses are complex regional pain syndrome; retention hyperkeratosis; diabetes. Treatments to date include physical therapy, medications. Diagnostic include electromyography with nerve damage (no date). In the treatment plan dated 3/13/15 the treating provider's plan of care includes requests for handicapped van with a lift; motorized mobility device; hydromorphone; Fossamax; Zofran; home health care.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ondansetron (Zofran) OT 8 mg sublingual #270: 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), Integrated treatment/disability duration guidelines, pain (chronic).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78 of 127.

**Decision rationale:** The patient is a 39 year old male who sustained an industrial injury in June of 2009 with a subsequent right shoulder injury. After subsequent surgery the patient developed increased discomfort and loss in range of motion. The request is for the use of Zofran medication which is used for nausea. Nausea is a common side effect of opioid use. Due to the fact that the ongoing use of the opioid hydromorphone requested is not certified, the request for zofran is not medically necessary.

**Fosamax 20 mg #12:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM; Occupational medicine practice guidelines; evaluation and management of common health problems and functional recovery.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 25 of 127.

**Decision rationale:** The MTUS guidelines state the following: "Recommend treatment of bone resorption with bisphosphonate-type compounds as an option for patients with CRPS Type I. Not recommended for other chronic pain conditions. Significant improvement has been found in limited studies of intravenous clodronate and intravenous alendronate. Alendronate (Fosamax) given in oral doses of 40 mg a day (over an 8 week period) produced improvements in pain, pressure tolerance and joint mobility. The effects may potentially involve avenues other than inhibition of bone resorption. (Manicourt, 2004) See also CRPS, medications. Bisphosphonates are a class of drugs that inhibit osteoclast action and the resorption of bone. Alendronate (Fosamax) is in this class." The patient is a 39 year old male who sustained an industrial injury in June of 2009 with a right shoulder injury. After subsequent surgery the patient developed increased discomfort and loss in range of motion. The request if for the use of fosamax to aid in pain relief of the diagnosed condition of CRPS. The MTUS guidelines as stated above do allow for the use of this medication. As such, the request is medically necessary.

**Hydromorphone 4 mg #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78 of 127.

**Decision rationale:** The patient is a 39 year old male who sustained an industrial injury in June of 2009 with a subsequent right shoulder injury. After subsequent surgery the patient developed increased discomfort and loss in range of motion. The request is for the use of the opioid hydromorphone. The MTUS guidelines state that for ongoing use of medication in this class their needs to be not only pain relief, but functional improvement seen. Also, screening measures should include documentation of side effects, physical and psychosocial functioning, and potential aberrant behaviors. This is not seen in the records. As such, the request is not medically necessary.

**Rental van and lift lease (months) #12:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Anthem clinical UM guideline, subject: Durable medical equipment Guideline # CG-DME-10.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Anthem clinical UM guidelines.

**Decision rationale:** The MTUS and ACOEM guidelines do not make any recommendations regarding the use of rental vehicles. The patient is a 39 year old male who sustained an industrial injury in June of 2009 with a subsequent right shoulder injury. After subsequent surgery the patient developed increased discomfort and loss in range of motion as well as other complications. There is inadequate documentation of disability rendering the patient unable to transport himself to and from appointments. As such, the request is not medically necessary.

**Motorized mobility device purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines power mobility devices Page(s): 99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99 of 127.

**Decision rationale:** The MTUS guidelines state the following regarding power mobility devices: "Not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care." The patient is a 39 year old male who sustained an industrial injury in June of 2009 with a subsequent right shoulder injury. After subsequent surgery the patient developed increased discomfort and loss in range of motion as well as other complications. The request is for the use of a power mobility device. There is insufficient documentation of the patient being non-ambulatory requiring a power mobility device. As such, the request is not medically necessary.

**Home health care every day (months) #12: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51 of 127.

**Decision rationale:** The MTUS guidelines state the following regarding home health: "Recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or "intermittent" basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. (CMS, 2004)" The request is for the use of daily home health services. The patient is a 39 year old male who sustained an industrial injury in June of 2009 with a subsequent right shoulder injury. After subsequent surgery the patient developed increased discomfort and loss in range of motion. There is inadequate documentation to support daily home health in this case as the patient would not be considered homebound. As such, the request is not medically necessary.