Case Number:	CM14-0093071		
Date Assigned:	07/25/2014	**Date of Injury:**	11/17/2011
Decision Date:	09/25/2014	**UR Denial Date:**	06/04/2014
Priority:	Standard	**Application Received:**	06/18/2014

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. The expert reviewer is Board Certified in Neurology, has a subspecialty in Neuromuscular Medecine and is licensed to practice in New Jersey. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 51-year-old man who sustained a work-related injury on November 17, 2011. Subsequently, he developed chronic right shoulder pain. The patient underwent rotator cuff repair in 1994, and right shoulder surgery on June 14, 2012 and march 12, 2013. His MRI dated on January 3, 2012 showed small paralabral cyst in lining of AC joint. X-ray dated May 21, 2014 showed degenerative change of the distal glenohumeral joint. According to a note dated May 21, 2014, the patient reported that his pain is ranging from 3-9/10 with muscle spasm aggravated by the use of his right arm. Pain medications improved the pain. He reported continued difficulty with all ADL's using both hands, severely disrupted sleep, and difficulty working and concentrating. On physical examination, the patient has a normal gait with normal cervical range of motion. There was negative Spurling's test. The right shoulder exam revealed well healed anterior surgical scar. There was tenderness in the anterior bicipital groove. The compression and rotation of the glenohuneral joint caused significant discomfort. There was positive crepitus with range of motion. On neurologic examination, the motor, sensory, and deep tendon reflexes were normal. The patient was diagnosed with degenerative joint disease of shoulder region, chronic pain syndrome, myalgia and myosilitis and symptoms of depression/anxiety. Prior treatment included physical therapy and medications (Prilosec, Ibuprofen, Soma, and Norco). The provider requested authorization for physical therapy, Ibuprofen, Soma, Temazepam and Ambien.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for the right shoulder, six (6) visits: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints,Chronic Pain Treatment Guidelines Physical Medicine Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder: Physical Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

Decision rationale: According to MTUS guidelines, Physical Medicine is "Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007)" There is no documentation of the efficacy, number of sessions and outcome of previous physical therapy sessions. There is no documentation that the patient cannot perform home exercise. Therefore, Physical therapy (6) is not medically necessary.

Ibuprofen 800mg #90 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects, Ibuprofen Page(s): 70, 72.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Nonselective NSAIDS Page(s): 107.

Decision rationale: According to MTUS guidelines, According to MTUS guidelines, Chronic Pain Medical Treatment Guidelines chapter, nonselective NSAIDS section, Ibuprofen is indicated for pain management of breakthrough of neck or back pain. The medication should be used at the lowest dose and for a short period of time. There is no documentation that the patient

developed exacerbation of his pain. There is no documentation about the duration of the prescription of Ibuprofen and the rationale behind that. There is no documentation that the lowest dose and shortest period is used for this patient. Although the patient developed a chronic right shoulder pain that may require Ibuprofen, there is no documentation that the provider recommended the lowest dose of Ibuprofen for the shortest period of time. Therefore, the prescription of Ibuprofen 800mg #90 with 3 refills is not medically necessary.

Soma 350mg #60 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics, Carisoprodol, Dosing Page(s): 64, 65.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Soma Page(s): 29.

Decision rationale: According to MTUS guidelines, a non-sedating muscle relaxants is recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic lumbosacral pain. Efficacy appears to diminish over time and prolonged use may cause dependence. According to the provided file, the patient was prescribed Soma for more than 3 weeks without clear evidence of spasm or exacerbation of shoulder pain. There is no justification for prolonged use of Soma. The request for Soma is not medically necessary.

Temazepam 30mg #30 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral interventions, Benzodiazepines Page(s): 24, 66. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter: Benzodiazepines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: According to MTUS guidelines, benzodiazepines are not recommended for long term use for pain management because of unproven long term efficacy and because of the risk of dependence. Most guidelines limit their use to 4 weeks. There is no recent documentation of insomnia related to pain. There is no clear documentation that the drug will be used for less than 4 weeks. Therefore the prescription of Temazepam 30mg, quantity 30 is not medically necessary.

Ambien 12.5 #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, Pain Chapter: Zolpidem (Ambien).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Non-Benzodiazepine sedative-hypnotics (Benzodiazepine-receptor agonists (http://worklossdatainstitute.verioiponly.com/odgtwc/pain.htm.

Decision rationale: According to ODG guidelines, Non-Benzodiazepine sedative-hypnotics (Benzodiazepine-receptor agonists): First-line medications for insomnia. This class of medications includes zolpidem (Ambien and Ambien CR), Zaleplon (Sonata), and Eszopicolone (Lunesta). Benzodiazepine-receptor agonists work by selectively binding to type-1 benzodiazepine receptors in the CNS. All of the benzodiazepine-receptor agonists are schedule IV controlled substances, which means they have potential for abuse and dependency. Ambien is not recommended for long-term use to treat sleep problems. It seems that the patient has been prescribed in the past without clear documentation of efficacy. Furthermore, there is no documentation of the use of non-pharmacologic treatment for the patient's sleep issue. Therefore, the prescription of Zolpidem Tartate (Ambien) for sleep aid is not medically necessary.