

<b>Case Number:</b>	CM14-0219352		
<b>Date Assigned:</b>	01/09/2015	<b>Date of Injury:</b>	03/29/2010
<b>Decision Date:</b>	03/06/2015	<b>UR Denial Date:</b>	12/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/31/2014

### 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. 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:

This is a 55 year old female who was injured as a result of repetitive stress while working. The date of injury was March 29, 2010. Diagnoses include left shoulder degenerative joint disease, left shoulder impingement syndrome and left bicipital tendinitis. On July 25, 2014, she underwent left total shoulder arthroplasty and biceps tenodesis. On December 4, 2014, the injured worker stated that she had sharp pains in her left shoulder. The pain was described as constant, achy and occasionally sharp in character. The shoulder had catching and popping at times. Without medication, her pain was rated as a 7 on the 1-10 pain scale and as a 4 on the pain scale with medication. Physical examination revealed limited range of motion in flexion of the left shoulder to 100 degrees and abduction to 80 degrees limited due to pain. The injured worker was noted to have very limited internal and external rotation. She had tenderness over the anterior, superior and lateral surface of the left shoulder. Medication was listed as treatment. A request was made for Norco 10/325mg #150, Cymbalta 60mg #30, Restoril 15mg #60, Gralise 600mg #90 and Abilify 5mg #30. On December 12, 2014, utilization review approved Norco 10/325mg #120, Cymbalta 60mg #30, Restoril 15mg #20 and Gralise 600mg #90. Utilization review denied the remaining Norco 10/325mg #30, the remaining Restoril 15mg #40 and Abilify 5m #30 citing MTUS and ODG guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg, #150:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen On-going management.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76.

**Decision rationale:** Norco is acetaminophen and hydrocodone, an opioid. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. Provider has failed to document appropriate assessment of objective improvement in pain and activity of daily living as required by MTUS guidelines. Medication is helpful and improvement in pain score is not an objective measure as per MTUS guidelines. The documentation does not meet MTUS guidelines. Norco is not medically necessary.

**Restoril 15mg, #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines. Decision based on Non-MTUS Citation ODG benzodiazepines

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

**Decision rationale:** Restoril or Temazepam is a benzodiazepine. As per MTUS Chronic pain guidelines is not recommended for long term use. There is strong risk of dependence and tolerance develops rapidly. Patient is on this medication for insomnia from sleep however, documentation specifically states that it is no longer working for sleep. The provider then fails to document why this medication is to be continued when it is not working. Restoril/Temazepam is not medically necessary.

**Abilify 5mg, #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Abilify (aripiprazole)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mental Illness and Stress

**Decision rationale:** MTUS Chronic pain and ACOEM Guidelines do have any sections that relate to this topic. As per Official Disability Guidelines, Abilify is not recommended as a first line treatment. It is an antipsychotic that may be used in patients with schizophrenia, bipolar disorder and major depression. The provider has only documented that it is for "pain and depression". There is no documentation of any efficacy, failure of first line therapy or

appropriate monitoring for side effects. Poor documentation does not support use of Abilify.  
Abilify is not medically necessary.