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| Case Number: | CM15-0036086 | | |
| Date Assigned: | 03/04/2015 | Date of Injury: | 11/05/2012 |
| Decision Date: | 06/09/2015 | UR Denial Date: | 02/04/2015 |
| Priority: | Standard | Application Received: | 02/25/2015 |

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: New York

Certification(s)/Specialty: Internal 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 49 year old female, who sustained a work related injury on 11/5/12. She lost control of her motor vehicle and hit a light pole. She sustained injuries to her head, left shoulder, neck, left knee and lower back. The diagnoses have included displacement cervical intervertebral disc without myelopathy, complete rupture of rotator cuff, tear lateral cartilage or meniscus knee, lumbago with bilateral radiculopathy and facet/sacroiliac joint arthropathy. Treatments to date have included a MRI of lumbar spine, x-rays of cervical spine, a MRI of left knee, physical therapy, home exercises, medications including Oxycontin and Oxycodone and left shoulder surgery 5/12/14. In the PR-2 dated 1/28/15, the injured worker complains of neck pain with pain that radiates down arms. She has tenderness to palpation of cervical spine and paraspinal musculature. She has muscle spasm. She has limited range of motion in her neck. She complains of left knee pain. She has lateral knee joint tenderness and limited flexion. She has a positive McMurry's lateral. She complains of left shoulder pain. She has decreased range of motion due to pain. She has subacromial joint tenderness. She has a positive cross-arm impingement test. She has a positive Hawkin's sign. She complains of low back pain with radiation of pain and numbness/tingling. No abnormal findings for lower back found on examination. The requests for certification include a MRI left shoulder, Oxycontin, Oxycodone, Intermezzo and acupuncture therapy. On 2/4/15, Utilization Review non-certified requests for a MRI left shoulder, Oxycontin ER 40mg., #90, Oxycodone 30mg., #240 and Intermezzo 3.5mg., #30. The California MTUS, Chronic Pain Treatment Guidelines, ACOEM Guidelines and ODG were cited. On 2/4/15, Utilization Review modified a request acupuncture therapy 2x/week for

weeks to neck, back and left shoulder to 3 acupuncture therapy visits. The California MTUS, Acupuncture Medical Treatment Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

L Shoulder MRI: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines; Work Loss Data Institute, LLC; Corpus Christi, TX; www.odg-twc.com; Section: Shoulder (Acute & Chronic) (updated 10/31/2014).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): Special Studies and Diagnostic and Treatment Considerations, pg 207.

Decision rationale: MTUS recommends ordering imaging studies when there is evidence of a red flag on physical examination (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems), failure to progress in a strengthening program intended to avoid surgery or clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment). The injured worker complains of persistent left shoulder pain despite previous shoulder surgery. Documentation indicates that Physical Therapy has been prescribe for the shoulder pain and there is no evidence of red flags or unexplained physical findings on examination that would warrant additional imaging at the time of the requested service under review. The request for L Shoulder MRI is not medically necessary by MTUS.

Acupuncture Therapy 2 times a week for 4 weeks Neck, Back and Left shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: MTUS states that Acupuncture has not been found to be effective in the management of back pain and is only recommended as an option in conjunction with active physical rehabilitation and/or surgical intervention to hasten functional recovery, using a short course of treatment. Initial trial of 3-4 visits over 2 weeks is recommended. With evidence of reduced pain, medication use and objective functional improvement, total of up to 8-12 visits over 4-6 weeks may be prescribed. Documentation shows that the injured worker complains of chronic pain in the neck, left shoulder and low back and diagnoses have included complete rupture of rotator cuff. Physician reports indicate that physical therapy is in progress for the left shoulder and cervical spine with reported improvement with exercise. MTUS does not recommend Acupuncture for the treatment of neck pain. For shoulder complains, acupuncture is recommended as an option for rotator cuff tendinitis. With MTUS guidelines not being met

completely, the request for Acupuncture Therapy 2 times a week for 4 weeks Neck, Back and Left shoulder is not medically necessary.

Oxycontin ER 40mg no. 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): 74 - 82.

Decision rationale: MTUS recommends that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects must be documented with the use of Opioids. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Guidelines recommend using key factors such as pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors, to monitor chronic pain patients on opioids. Assessment for the likelihood that the patient could be weaned from opioids is recommended if there is no overall improvement in pain or function, unless there are extenuating circumstances and if there is continuing pain with the evidence of intolerable adverse effects. The injured worker complains of chronic neck, left shoulder and low back pain. Documentation fails to demonstrate a recent urine drug screen or supporting evidence of significant improvement in the injured worker's pain or level of function to justify continued clinical use of opioids. In the absence of significant response to treatment, the request for Oxycontin ER 40mg no. 90 is not medically necessary.

Oxycodone 30mg no. 240: 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): 74 - 82.

Decision rationale: MTUS recommends that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects must be documented with the use of Opioids. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Guidelines recommend using key factors such as pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors, to monitor chronic pain patients on opioids. Assessment for the likelihood that the patient could be weaned from opioids is recommended if there is no overall improvement in pain or function, unless there are extenuating circumstances and if there is continuing pain with the evidence of intolerable adverse effects. The injured worker complains of chronic neck, left shoulder and low back pain. Documentation fails to demonstrate a recent urine drug screen or supporting evidence of significant improvement in the injured worker's pain or level of function to justify continued clinical use of opioids. In the absence of significant response to treatment, the request

for Oxycodone 30mg no. 240 is not medically necessary.

Intermezzo 3.5mg no. 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Not addressed. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Insomnia treatment.

Decision rationale: Zolpidem is a prescription short-acting non benzodiazepine hypnotic, used for treatment of insomnia. Per guidelines, hypnotics are not recommended for long-term use and should be limited to three weeks maximum in the first two months of injury only. Use in the chronic phase is discouraged. While sleeping pills are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. Given that the injured worker has chronic pain syndrome with no documented diagnosis of sleep disorder, the medical necessity for continued use of Ambien has not been established. The request for Ambien is not medically necessary based on ODG. Documentation provided shows that the injured worker is diagnosed with Insomnia and has been prescribed Intermezzo (Ambien) for a period much longer than recommended by guidelines. The request for Intermezzo 3.5mg no. 30 is not medically necessary.