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| Case Number: | CM14-0100179 | | |
| Date Assigned: | 09/16/2014 | Date of Injury: | 04/16/2014 |
| Decision Date: | 10/20/2014 | UR Denial Date: | 06/24/2014 |
| Priority: | Standard | Application Received: | 06/30/2014 |

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 Physical Medicine and Rehabilitation and is licensed to practice in California. 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 58 year old female who sustained a cumulative injury on 04/16/2014. Prior treatment history included ibuprofen 800 mg. Progress report dated 06/04/2014 documented the patient to have complaints of right shoulder pain rated as an 8/10. The pain radiates into the neck and right upper extremity. The pain increases with activity and causes difficulty with activities of daily living. She reported difficulty with sleeping on the right shoulder. She complained of aching pain in the right hand with locking of the middle and index finger. She rated the pain as 10/10. The pain radiates to the thumb, index, middle and index finger. On review of systems, the patient denied any gastrointestinal complaints. On exam, the right shoulder revealed evidence of dislocation and fracture. There is tenderness to palpation over the anterior aspect of the shoulder, suprascapular muscles, acromioclavicular joint and the acromion. Shoulder range of motion revealed forward flexion on the right at 120 degrees and left at 160 degrees; abduction on the right at 125 degrees and on the left at 155 degrees; adduction is 30 degrees bilaterally; extension is 30 degrees on the right and 40 degrees on the left; internal rotation is 45 degrees on the right and 60 degrees on the left; and external rotation is 50 degrees on the right and 75 degrees on the left. The wrists and hands revealed no gross deformity. There is no evidence of swelling or laceration. The range of motion of the wrists revealed dorsiflexion to 50 degrees bilaterally; palmar flexion to 55 degrees on the right and 50 degrees on the left; ulnar deviation to 25 degrees bilaterally; and radial deviation to 15 degrees bilaterally. The patient had positive Tinel's sign, Phalen's and sensory deficit. The patient is diagnosed with right shoulder impingement syndrome, right carpal tunnel syndrome, painful triggering of the index, middle and ring fingers; musculoligamentous strain of the cervical spine, anxiety and insomnia. The patient was recommended Norco 5/325 mg and omeprazole 20 mg for stomach protection. Prior utilization review dated 06/24/2014 states the request for Norco 5/325mg #60 is

modified to certify Norco 5/325 mg #30 for weaning purposes; Omeprazole 20mg #30 is not certified as it is not medically supported.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 5/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-77.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-96.

Decision rationale: Norco (Hydrocodone + Acetaminophen) is indicated for moderate to severe pain. It is classified as a short-acting opioids, often used for intermittent or breakthrough pain. Guidelines indicate "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 guidelines state continuation of opioids is recommended if the patient has returned to work and if the patient has improved functioning and pain. The medical records do not establish failure of non-opioid analgesics, such as NSAIDs or acetaminophen. There is little to no documentation of any significant improvement in pain level (i.e. VAS) or function with prior use to demonstrate the efficacy of this medication. There is no evidence of return to work. There is no evidence of urine drug test in order to monitor compliance. The medical documents do not support continuation of opioid pain management. Therefore, based on guidelines and a review of the evidence, the request for Norco is not medically necessary.

Omeprazole 20mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PPI Page(s): 68.

Decision rationale: According to the CA MTUS, Omeprazole (Prilosec) "PPI" is recommended for Patients at intermediate risk for gastrointestinal events. The CA MTUS guidelines state PPI medications such as Omeprazole (Prilosec) may be indicated for patients at risk for gastrointestinal events, which should be determined by the clinician: 1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Treatment of dyspepsia secondary to NSAID therapy recommendation is to stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI. The guidelines

recommend GI protection for patients with specific risk factors, however, the medical records do not establish the patient is at significant risk for GI events. In fact the IW denies any GI upset and there is no documentation of any GI events. In accordance with the CA MTUS guidelines, Prilosec is not medically necessary.