

<b>Case Number:</b>	CM14-0159665		
<b>Date Assigned:</b>	10/24/2014	<b>Date of Injury:</b>	08/16/2011
<b>Decision Date:</b>	12/03/2014	<b>UR Denial Date:</b>	09/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/29/2014

### 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 & Rehabilitation and Pain Management, has a subspecialty in Interventional Spine 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 50-year-old female with a date of injury of August 16, 2011. The listed diagnosis per [REDACTED] is status post arthroscopy of the left shoulder on 07/08/2014. According to progress report July 17, 2014, the patient presents for an initial postoperative examination of the left shoulder. The patient states she is doing well but continues to have some residual pain. On a pain scale, her pain is rated as 5/10. Examination finding revealed limited range of motion to the shoulder as well as decreased strength in the internal and external rotation. X-rays were taken at the left shoulder and left humerus, the treating physician states "healing well." The treating physician is requesting extension of postoperative physical therapy 3 times a week for 4 weeks and medications. Utilization review denied the request on September 10, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Orphenadrine/Caffeine 20/10mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines muscle relaxants Page(s): 63,64.

**Decision rationale:** This is a request for orphenadrine/caffeine. Regarding muscle relaxants, Chronic Pain Medical Treatment Guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. The ACOEM Practice Guidelines states, that muscle relaxants seem no more effective than NSAIDs for treating patients with musculoskeletal problems, and using them in combination with NSAIDs has no demonstrated benefit, although they have been shown to be useful as antispasmodics. They may hinder return to function by reducing the patient's motivation or ability to increase activity. Regarding Orphenadrine, guidelines states that it is similar to diphenhydramine, but has greater anticholinergic effects and side effects include drowsiness, urinary retention and dry mouth. Side effects may limit use in the elderly. This medication has been reported in case studies to be abused for euphoria and to have mood-elevating effects. The Chronic Pain Medical Treatment Guidelines cautions its use due to its drowsiness and potential misuse. Long-term use of this medication is not supported. The medical file provided for review does not discuss this medication. It appears to be an initial request. There is no discussion as to why this medication is prescribed, as physical examination does not indicate muscle spasms. Furthermore, the treating physician has prescribed this medication without specifying duration of use. Long-term use of this medication is not supported and given the treating physician has not provided quantity, the request is not medically necessary.

**Gabapentin/Pyridoxine 250mg/10mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18 and 19. Decision based on Non-MTUS Citation AETNA Guidelines number 0536 discuss vitamin B12

**Decision rationale:** The treating physician is requesting gabapentin/pyridoxine. The Chronic Pain Medical Treatment Guidelines states that gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and post-therapeutic neuralgia, and has been considered a first-line treatment for neuropathic pain. Pyridoxine is a form of vitamin B-12. The ACOEM, MTUS, and ODG Guidelines do not discuss Pyridoxine. AETNA Guidelines number 0536 discuss vitamin B-12 therapy for medical conditions and considers it for anemia, GI disorders, neuropathy due to malnutrition, alcoholism, pernicious anemia, and posterolateral scoliosis. This appears to be an initial request for this medication. In this case, the patient does not meet the indication for gabapentin, as there are no radicular symptoms noted. In addition, based on current evidence, it does not appear that vitamin B-12 is supported for chronic pain. The requested is not medically necessary.

**Omeprazole 10mg/Flurbuprofin 100mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 22,69.

**Decision rationale:** The treating physician is requesting omeprazole/flurbiprofen. For anti-inflammatory medications, the Chronic Pain Medical Treatment Guidelines states that anti-inflammatories are the traditional first line of treatment to reduce pain, so activity and functional restoration can resume, but long-term use may not be warranted. The Chronic Pain Medical Treatment Guidelines also state that Omeprazole is recommended with precaution for patients at risk for gastrointestinal events: (1) Age is greater than 65, (2) History of peptic ulcer disease and GI bleeding or perforation, (3) Concurrent use of ASA or corticosteroid and/or anticoagulant, (4) High dose/multiple NSAID. This is an initial request for this medication. Although NSAIDs are indicated for chronic pain, the treating physician does not provide a discussion as to why a combination medication is required. There is no GI risk assessment to determine the patient's need for prophylactic PPI's to be used in conjunction with an NSAID. Therefore, the request is not medically necessary.

**Flurbuprofin/Cyclo/Menthol Cream 20%/10%/4%:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49,Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 117-119. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111.

**Decision rationale:** The treating physician is requesting a compound topical cream, which includes flurbiprofen 20%, cyclobenzaprine 10%, and menthol 4%. The Chronic Pain Medical Treatment Guidelines states that topical analgesics are largely experimental and use with few randomized control trials to determine efficacy or safety. Guidelines further states, that any compounded product that contains at least one (or drug class) that is not recommended is not recommended. According to guidelines, Cyclobenzaprine is a muscle relaxant and not recommended in topical formulation. Therefore, the entire compound cream is not supported and the request is not medically necessary.

**Keratek Gel (4-ounce bottle):** 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)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111.

**Decision rationale:** The treating physician is requesting Keratek Gel. This is an initial request. Keratek is a topical analgesic that contains methyl salicylate 28% and menthol 16%. The Chronic Pain Medical Treatment Guidelines allows for the use of topical NSAID for peripheral

joint arthritis and tendonitis. In this case, the patient does not present with such a condition for which topical NSAIDs may be indicated. The patient has shoulder pain. The Chronic Pain Medical Treatment Guidelines states that there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Therefore, the request is not medically necessary.

**Diclofenac/Lidocaine 3%/15% 180mg: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111.

**Decision rationale:** The treating physician is requesting diclofenac/lidocaine 3%/15% 180 mg topical cream. The Chronic Pain Medical Treatment Guidelines states that topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety. Guidelines further states that any compounded product that contains at least one (or drug class) that is not recommended is not recommended. According to the Chronic Pain Medical Treatment Guidelines, Lidocaine is only allowed in a patch form and not allowed in cream, lotion or gel forms. Therefore, the entire compound cream cannot be supported. Therefore, the request is not medically necessary.

**Vicosetron Hydrocodone/APAP 10/325: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, antiemetic

**Decision rationale:** The treating physician is requesting Vicosetron, which includes hydrocodone and ondansetron 10/325 mg. This is an initial request for this medication. The treating physician does not discuss why a compound medication is being requested. For Hydrocodone, the Chronic Pain Medical Treatment Guidelines states that the criteria for initiating opioids recommends that reasonable alternatives have been tried, consider patient's likelihood of improvement, likelihood of abuse, etc. Guidelines go on to state that baseline pain and functional assessments should be made. Once the criteria have been met, a new course of opioids may be tried at that time. Regarding antiemetic, the Official Disability Guidelines states that it is not recommended for nausea and vomiting secondary to chronic opiate use. Recommended for acute use as noted below for FDA-approved indications. Ondansetron (Zofran), this drug is a serotonin 5-HT<sub>3</sub> receptor antagonist. It is FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA approved for

postoperative use. The Official Disability Guidelines do support the use of Ondansetron for postoperative use. However, recommendation for this compound medication cannot be made, as the treating physician has not provided baseline pain or any functional assessments to necessitate the start of Hydrocodone. Therefore, the request is not medically necessary. ODG Guidelines do support the use of Ondansetron for postoperative use. But, recommendation for this compound medication cannot be made as the treater has not provided baseline pain or any functional assessments to necessitate the start of Hydrocodone. The requested compound medication including Hydrocodone and Ondansetron is not medically necessary and recommendation is for denial.

**Additional Physical Therapy (12-sessions for the left shoulder):** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 83, Chronic Pain Treatment Guidelines Physical Therapy Page(s): 103.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder chapter, physical medicine

**Decision rationale:** The treating physician is requesting additional post-operative physical therapy 3 times a week for 4 weeks to regain strengthening and improving range of motion to the left shoulder. For postsurgical physical therapy treatment, the Official Disability Guidelines recommends 24 visits over 14 weeks following an arthroscopy. The medical file provided for my review does not include physical therapy treatment reports. Utilization review indicates that the patient underwent 12 sessions to date and partially approved additional 4 visits of physical therapy to allow completion of PT and full transition to HEP. In this case, the patient has participated in 12 post-op physical therapy sessions with some residual pain. The additionally requested 12 sessions is within guidelines and therefore the request is medically necessary.