

Case Number:	CM14-0169498		
Date Assigned:	10/30/2014	Date of Injury:	08/23/2005
Decision Date:	12/05/2014	UR Denial Date:	10/07/2014
Priority:	Standard	Application Received:	10/14/2014

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, 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 40-year-old male with date of injury of 08/23/2005. The listed diagnoses per [REDACTED] from 09/17/2014 are: 1. Neck sprain. 2. Pain in the joint involving the shoulder. 3. Status post left shoulder impingement syndrome from 09/30/2014. According to the 08/20/2014 report, the patient continues to have pain in the bilateral shoulders which is worse when lifting. The patient rates his pain 8/10. The examination shows the patient remains symptomatic to the bilateral shoulders with decreased strength in the internal and external rotation. The provider mentions an MRI scan that showed evidence of a large partial tear of the rotator cuff of the left shoulder with impingement syndrome. X-rays were taken on 08/20/2014 of the bilateral shoulders and bilateral humerus sprain on the under surface of the acromion; however, results were not make available for review. The patient's current medication include Norco. The documents include UDS from 09/17/2014 and 10/08/2014, an MRI of the left shoulder from 04/15/2014 and a left shoulder arthroscopy operative report from 09/30/2014. The utilization review denied the request on 10/07/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain pump: 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) Shoulder

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 on Pain Pumps

Decision rationale: This patient presents with bilateral shoulder pain. The patient is status post left shoulder impingement surgery from 09/30/2014. The provider is requesting a pain pump. The MTUS and ACOEM Guidelines do not address this request; however, ODG Guidelines under the Shoulder Chapter for postoperative pain pump states, "Not recommended. Three recent moderate quality RCTs did not support the use of pain pumps. Before these studies, evidence supporting the use of ambulatory pain pumps existed primarily in the form of small case series, and poorly designed, randomized, control studies with small populations...This study concluded that infusion pumps did not significantly reduce pain levels." In this case, it appears that the provider is requesting a pain pump following the patient's left shoulder surgery, and ODG Guidelines do not support its use following surgery. Therefore, the request for the pain pump is not medically necessary and appropriate.

Shoulder immobilizer: 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) Shoulder

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, Immobilizations.

Decision rationale: This patient presents with bilateral shoulder pain. The patient is status post left shoulder impingement surgery from 09/30/2014. The provider is requesting a shoulder immobilizer. The MTUS and ACOEM Guidelines do not address this request; however, ODG Guidelines under the Shoulder Chapter for immobilizations states, "Not recommended as a primary treatment. Immobilization and rest appear to be overused as treatment. Early mobilization benefits include earlier return to work; decreased pain, swelling, and stiffness; and a greater preserved range of joint motion, with no increased complications. With the shoulder, immobilization is also a major risk factor for developing adhesive capsulitis, also termed "frozen shoulder". The provider is requesting a shoulder immobilizer for post-operative recovery. In this case, ODG Guidelines do not support the use of shoulder immobilizer as a primary treatment following shoulder surgery. Therefore, the request is not medically necessary and appropriate

Compound Orphenadrine/Caffeine 50/10mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-64.

Decision rationale: This patient presents with bilateral shoulder pain. The patient is status post left shoulder impingement surgery from 09/30/2014. The provider is requesting a compound Orphenadrine/Caffeine 50/10 mg #60. The MTUS Guidelines page 63 on muscle relaxants for pain states that it recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with low back pain. Furthermore, MTUS page 64 on Orphenadrine states that this drug is similar to Diphenhydramine but has greater anticholinergic effects. The records show that the patient was prescribed compound Orphenadrine/Caffeine on 09/17/2014. In this case, MTUS does not support the long-term use of muscle relaxants. Furthermore, the provider does not explain why a compound medication is needed to address the patient's chronic pain. Therefore, the requested medication is not medically necessary and appropriate.

Compound Gabapentin/Pyridoxine 250/10mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) and National Guideline Clearinghouse.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin; Medications Used for Chronic Pain, Page(s): 18-19;60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Carpal Tunnel Syndrome Chapter on Vitamin B6X.

Decision rationale: This patient presents with bilateral shoulder pain. The patient is status post left shoulder impingement surgery from 09/30/2014. The provider is requesting compound Gabapentin/Pyridoxine 250/10 mg #60. The MTUS Guidelines pages 18 and 19 on Gabapentin states that it has been shown to be effective for the treatment of diabetic painful neuropathy and postherpetic neuralgia. It has been considered as a first line treatment for neuropathic pain. MTUS page 60 states that for medications used for chronic pain, efficacy in terms of pain reduction and functional gains must also be documented. In addition, for pyridoxine ODG guidelines under the carpal tunnel syndrome chapter on vitamin B6 (pyridoxine) states, "Not recommended. Vitamin B6 (pyridoxine) is often used in CTS when it is perceived to be deficient, but this practice is not consistently supported by medical evidence. Vitamin B6 does not significantly improve overall symptoms. There is limited evidence that vitamin B6 improves finger swelling and movement discomfort with 12 weeks of treatment." The records show that the patient was prescribed compound Gabapentin/Pyridoxine on 09/17/2014. In this case, pyridoxine is currently not supported by the ODG guidelines. Furthermore, the provider does not explain why a compound medication is warranted. Therefore, the medication is not medically necessary.

Compound Omeprazole/Flurbiprofen 10/100mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs GI Symptoms And Cardiovascular Risks; Anti-Inflammatory Medications; Medications For Chro.

Decision rationale: This patient presents with bilateral shoulder pain. The patient is status post left shoulder impingement surgery from 09/30/2014. The provider is requesting a compound Omeprazole/Flurbiprofen 10/100 mg #60. The MTUS Guidelines, pages 68 and 69, on NSAIDs GI symptoms and cardiovascular risks, states that it is recommended with precaution to determine if patient are at risk for gastrointestinal events: 1) ages greater than 65; 2) history of peptic ulcer, GI bleed or perforation; 3) concurrent use of ASA or corticosteroids and anticoagulants; and 4) high-dose multiple NSAIDs. In addition, for Flurbiprofen, the MTUS Guidelines, page 22, on anti-inflammatory medications, states that anti-inflammatories are the traditional first line treatment to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. MTUS page 60 on medications for chronic pain, states that pain assessment and functional changes must also be noted when medications are used for chronic pain. The records show that the patient was prescribed combination medication Omeprazole/Flurbiprofen on 09/17/2014. The provider does not discuss gastrointestinal events or issues. While the patient can benefit from anti-inflammatory medication following surgery, the provider does not state why a compound Omeprazole/Flurbiprofen is recommended. No GI risk assessment is provided to warrant a prophylactic use of PPI with an oral NSAID. Furthermore, there is no documentation of medication efficacy as it relates to the use of this compound medication. Therefore, the medication is not medically necessary

Compound Hydrocodone 10/325mg/Ondansetron 300/2mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids; On-Going Management Page(s): 88-89,78.

Decision rationale: This patient presents with bilateral shoulder pain. The patient is status post left shoulder impingement surgery from 09/30/2014. The provider is requesting a Compound Hydrocodone 10/325mg/Ondansetron 300/2mg #60. For chronic opiate use, the MTUS Guidelines, pages 88 and 89, on criteria for use of opioids states, "Pain should be assessed at each visit, and functioning should be measured at six-month intervals using a numerical scale or validated instrument." MTUS page 78 on ongoing management, also require documentations of the 4 A's including analgesia, ADLs, adverse side effects, and aberrant drug-seeking behavior, as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medications to work, and duration of pain relief. In addition, an ODG guideline on Ondansetron (Zofran) does not support anti-emetics for nausea and vomiting due to chronic opiates. Zofran is specifically recommended for nausea and vomiting secondary to chemotherapy and radiation treatment following surgery and

for acute use of gastroenteritis. The records show that the patient was prescribed the compound Hydrocodone/Ondansetron on 09/17/2014. The provider notes on 08/20/2014 that the patient's urine toxicology screen is compliant. The UDS performed on 09/17/2014 and 10/08/2014 show consistent results with prescribed medications. The provider does not provide specifics regarding ADLs, no significant improvement, no mention of quality of life changes, and no discussions regarding "pain assessments" as required by MTUS. There is no discussion as to why a compound Hydrocodone and Ondansetron medication is required. In addition, Ondansetron is recommended specifically for nausea and vomiting secondary to chemotherapy and radiation which this patient does not present with. Therefore, the medication is not medically necessary.

Compound Flurbiprofen/Cyclo/Menthol 20%/10%/4% cream 180gm: Upheld

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

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

Decision rationale: This patient presents with bilateral shoulder pain. The patient is status post left shoulder impingement surgery from 09/30/2014. The provider is requesting a compound Flurbiprofen/Cyclobenzaprine/Menthol 20%/10%/4% cream 180 mg. The MTUS Guidelines page 111 on topical analgesic state that it is largely experimental in use with few randomized control trials to determine efficacy or safety. It is primarily recommended for neuropathic pain when trials of anti-depressants and anticonvulsants have failed. MTUS further states, any "compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, Cyclobenzaprine, a muscle relaxant, is currently not recommended in topical formulation. Therefore, the medication is not medically necessary.

Kera-Tek Gel 4oz: Upheld

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

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

Decision rationale: This patient presents with bilateral shoulder pain. The patient is status post left shoulder impingement surgery from 09/30/2014. The provider is requesting Kera-Tek gel 4 OZ. The MTUS Guidelines page 111 on topical NSAIDs states, "topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment of osteoarthritis, but either nor afterward or with diminishing effect over another 2-week period." It is indicated for short term use between 4 to 12 weeks for the treatment of osteoarthritis and tendonitis in particular that of the knee and elbow or other joints that are amenable to topical treatment. It has not been evaluated for treatment of the spine, hip or shoulder. The records show that the patient was prescribed Kera-Tek gel in 09/17/2014. In this case, topical NSAIDs are

indicated for patients with osteoarthritis and tendonitis which this patient does not present with. Therefore, the medication is not medically necessary.

Compound Diclofenac/Lidocaine 3%/5% 180gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic Page(s): 111-113.

Decision rationale: This patient presents with bilateral shoulder pain. The patient is status post left shoulder impingement surgery from 09/30/2014. The provider is requesting a compound Diclofenac/Lidocaine 3%/5% 180 g. The MTUS Guidelines page 111 state that topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment of osteoarthritis. It is, however, indicated for short term use between 4 to 12 weeks. It is indicated for patients with osteoarthritis and tendonitis in particular of that of the knee and elbow or other joints that are amenable to topical treatment. There is little evidence to utilize topical NSAIDs for the treatment of osteoarthritis of the spine, hip, or shoulder. In addition, the MTUS Guidelines page 112 on topical Lidocaine states, "recommended for localized peripheral pain after there has been evidence of first-line therapy (tricyclic or SNRI antidepressants, or an AED such as Gabapentin or Lyrica.) Topical Lidocaine, in the formulation of a dermal patch (Lidoderm) has been designed for orphan status by the FDA for neuropathic pain. MTUS further states that no other commercially approved topical formulations of Lidocaine, whether creams, lotions, or gels, are indicated for neuropathic pain." In this case, Diclofenac is not recommended for the treatment of osteoarthritis of the shoulder. And Lidocaine is currently not approved in formulations other than a dermal patch. Therefore, the medication is not medically necessary.

Urine drug test: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) under Pain Chapter, Urine Drug Testing.

Decision rationale: This patient presents with bilateral shoulder pain. The patient is status post left shoulder impingement surgery from 09/30/2014. The provider is requesting a URINE DRUG TEST. The MTUS Guidelines do not specifically address how frequent urine drug screens should be obtained for various risk opiate users. However, ODG Guidelines provide clear recommendations. For low-risk opiate users, once yearly urine drug screen is recommended following initial screening within the first 6 months. The 08/20/2014 report notes that the patient's current medications include Norco. The records show 2 urine drug screens from 09/17/2014 and 10/08/2014 that showed consistent results to prescribed medications. It appears that the provider is requesting a decision for the urine drug screen performed on

09/17/2014. No other urine drug screens prior to the 09/17/2014 report were made available for review. In this case, ODG Guidelines do support a yearly urine drug screen. While the provider does not discuss risk assessment, the request is reasonable. Therefore, urine drug test is medically necessary and appropriate.