

Case Number:	CM14-0098146		
Date Assigned:	07/28/2014	Date of Injury:	11/21/2011
Decision Date:	12/23/2014	UR Denial Date:	06/05/2014
Priority:	Standard	Application Received:	06/26/2014

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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 49-year-old female with an 11/21/11 date of injury. At the time (6/5/14) of Decision for MRI of the left shoulder, Omeprazole 20mg #30 with 2 refills, Orphenadrine ER 100mg #60 with 2 refills, Docusate 100mg #100 with 2 refills, and Hydrocodone 5/325mg #60 with 1 refill, there is documentation of subjective (left shoulder pain and diffuse body pain) and objective (decreased range of motion of the bilateral shoulders, positive impingement sign, grip weakness of the bilateral hands, positive Phalen's and Tinel's tests, reduced sensation in the bilateral median nerve distribution, decreased distal median distribution over the cervical spine, decreased range of motion of the cervical spine, tenderness to palpation over the cervical and lumbar paravertebral muscles, and decreased range of motion of the lumbar spine) findings, current diagnoses (bilateral shoulder tendinosis and impingement, bilateral elbow tendinosis, bilateral wrist tendinosis with carpal tunnel syndrome, cervical myofascial pain, lumbar radiculopathy, and lumbar disc protrusion), and treatment to date (acupuncture and medications (including ongoing treatment with Ketoprofen, Hydrocodone, Orphenadrine, and Omeprazole)). Regarding MRI of the left shoulder, there is no documentation of preoperative evaluation of partial thickness or large full-thickness rotator cuff tears; acute shoulder trauma, suspect rotator cuff tear/impingement; normal plain radiographs; subacute shoulder pain, or suspect instability/labral tear. Regarding Omeprazole 20mg #30, there is no documentation of risk for gastrointestinal event (high dose/multiple NSAID). Regarding Orphenadrine ER 100mg #60, there is no documentation of acute exacerbation of chronic low back pain; short-term (less than two weeks) treatment; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Orphenadrine use to date. Regarding Docusate 100mg #100 with 2 refills, there is no documentation of a

diagnosis/condition for which Docusate is indicated (short-term treatment of constipation and/or chronic opioid use). Regarding Hydrocodone 5/325mg #60, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Hydrocodone use to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Magnetic Resonance Imaging (MRI).

Decision rationale: MTUS reference to ACOEM Guidelines identifies documentation of preoperative evaluation of partial thickness or large full-thickness rotator cuff tears, as criteria necessary to support the medical necessity of shoulder MRI. ODG identifies documentation of acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs; subacute shoulder pain, or suspect instability/labral tear, as criteria necessary to support the medical necessity of shoulder MRI. Within the medical information available for review, there is documentation of diagnoses of bilateral shoulder tendinosis and impingement, bilateral elbow tendinosis, bilateral wrist tendinosis with carpal tunnel syndrome, cervical myofascial pain, lumbar radiculopathy, and lumbar disc protrusion. However, despite documentation of subjective (left shoulder pain) and objective (decreased range of motion of the bilateral shoulders, positive impingement sign, grip weakness of the bilateral hands, positive Phalen's and Tinel's tests, and reduced sensation in the bilateral median nerve distribution) findings, there is no documentation of preoperative evaluation of partial thickness or large full-thickness rotator cuff tears; acute shoulder trauma, suspect rotator cuff tear/impingement; normal plain radiographs; subacute shoulder pain, or suspect instability/labral tear. Therefore, based on guidelines and a review of the evidence, the request for MRI of the left shoulder is not medically necessary.

Omeprazole 20mg #30 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, Proton Pump Inhibitor.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Proton Pump Inhibitors (PPIs), Other

Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that risk for gastrointestinal event includes age > 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; and/or high dose/multiple NSAID. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of risk for gastrointestinal events, preventing gastric ulcers induced by NSAIDs, as criteria necessary to support the medical necessity of Omeprazole. Within the medical information available for review, there is documentation of diagnoses of bilateral shoulder tendinosis and impingement, bilateral elbow tendinosis, bilateral wrist tendinosis with carpal tunnel syndrome, cervical myofascial pain, lumbar radiculopathy, and lumbar disc protrusion. However, despite documentation of ongoing treatment with Ketoprofen, there is no documentation of risk for gastrointestinal event (high dose/multiple NSAID). Therefore, based on guidelines and a review of the evidence, the request for Omeprazole 20mg #30 with 2 refills is not medically necessary.

Orphenadrine Er 100mg #60 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for Pain) Page(s): 63-64. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle Relaxants (for Pain), Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of acute exacerbation of chronic low back pain and used as a second line option for short-term treatment, as criteria necessary to support the medical necessity of muscle relaxant. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that muscle relaxants are recommended for short-term (less than two weeks) treatment. Within the medical information available for review, there is documentation of diagnoses of bilateral shoulder tendinosis and impingement, bilateral elbow tendinosis, bilateral wrist tendinosis with carpal tunnel syndrome, cervical myofascial pain, lumbar radiculopathy, and lumbar disc protrusion. In addition, there is documentation of Orphenadrine used as a second line option. However, despite documentation of muscle spasms, and given documentation of an 11/21/11 date of injury, there is no documentation of acute muscle spasms, or acute exacerbation of chronic low back pain. In addition, given documentation of ongoing treatment with Orphenadrine Citrate ER, there is no documentation of short-term (less than two weeks) treatment and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Orphenadrine use

to date. Therefore, based on guidelines and review of the evidence, the request for Orphenadrine ER 100mg #60 with 2 refills is not medically necessary.

Docusate 100mg #100 with 2 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria For Use Of Opioids; Initiating Therapy Page(s): 77. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Opioid Induced Constipation, Other Medical Treatment Guideline or Medical Evidence: <http://www.drugs.com/ppa/docusate.html>.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that when initiating opioid therapy, prophylactic treatment of constipation should be initiated. ODG identifies that opioid-induced constipation is a common adverse effect of long-term opioid use. Medical Treatment Guideline identifies documentation of a diagnosis/condition for which Docusate is indicated (such as short-term treatment of constipation and/or chronic opioid use), as criteria necessary to support the medical necessity of Docusate. Within the medical information available for review, there is documentation of diagnoses of bilateral shoulder tendinosis and impingement, bilateral elbow tendinosis, bilateral wrist tendinosis with carpal tunnel syndrome, cervical myofascial pain, lumbar radiculopathy, and lumbar disc protrusion. However, there is no documentation of a diagnosis/condition for which Docusate is indicated (short-term treatment of constipation and/or chronic opioid use). Therefore, based on guidelines and a review of the evidence, the request for Docusate 100mg #100 with 2 refills with 1 refill is not medically necessary.

Hydrocodone 5/325mg #60 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of bilateral shoulder tendinosis and impingement, bilateral elbow tendinosis, bilateral wrist tendinosis with carpal tunnel syndrome, cervical myofascial pain,

lumbar radiculopathy, and lumbar disc protrusion. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, given documentation of ongoing treatment with Hydrocodone, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Hydrocodone use to date. Therefore, based on guidelines and a review of the evidence, the request for Hydrocodone 5/325mg #60 with 1 refill is not medically necessary.