

Case Number:	CM15-0140458		
Date Assigned:	07/30/2015	Date of Injury:	01/15/2011
Decision Date:	09/23/2015	UR Denial Date:	07/16/2015
Priority:	Standard	Application Received:	07/20/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 57 year old male, who sustained an industrial injury on January 15, 2011. The injured worker was diagnosed as having a partial thickness tear of the rotator cuff and failed arthroscopic surgery. Treatment and diagnostic studies to date has included magnetic resonance imaging, medication regimen, and above noted procedure. In a progress note dated February 12, 2015 the treating physician reports complaints of severe pain to the left shoulder. Examination reveals positive impingement, decreased range of motion, and positive Hawkins ad drop arm test. The documentation provided did not indicate the injured worker's pain level as rated on a pain scale prior to use of his medication regimen and after use of his medication regimen to indicate the effects with the use of the injured worker's current medication regimen. Also, the documentation provided did not indicate if the injured worker experienced any functional improvement with use of his medication regimen. The treating physician requested Meloxicam 15mg with a quantity of 30 for soft tissue swelling and inflammation; Protonix 20mg with a quantity of 30 for gastrointestinal protection noting that the injured worker has gastrointestinal sensitivity to non-steroidal anti-inflammatory medications; Hydrocodone 10/325mg with a quantity of 60 for pain; Ultram ER 150mg with a quantity of 60 for lower level pain; and Terocin Cream and patches for topical analgesia. The treating physician also requested Ketorolac DMSO gel, but the documentation provided did not indicate the specific reason for the requested medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Meloxicam 15mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Page(s): 22.

Decision rationale: The patient presents with pain in the right shoulder. The request is for MELOXICAM 15 MG #30. Patient is status post right shoulder arthroscopic repair surgeries, 10/2011 and 04/2012, Physical examination to the right shoulder on 09/19/14 revealed tenderness to palpation in the region of the rotator cuff insertion. Range of motion was limited with flexion and lateral abduction. Impingement, Hawkins and drop arm tests were positive. Patient's treatments have included physical therapy, medication and cortisone injections. Per 06/22/15 Request for Authorization Form, patient's diagnosis includes RTC impingement. Patient's medications, per 03/26/15 progress report include Meloxicam, Protonix, Hydrocodone, Ultram, and Terocin Patch. Per 02/12/15 report, patient is to remain off-work. MTUS Chronic Pain Medical Treatment Guidelines, pg 22 for Anti-inflammatory medications states: 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. A comprehensive review of clinical trials on the efficacy and safety of drugs for the treatment of low back pain concludes that available evidence supports the effectiveness of non-selective non-steroidal anti-inflammatory drugs (NSAIDs) in chronic LBP and of antidepressants in chronic LBP. Per 03/26/15 progress report, treater's reason for prescribing Meloxicam is for soft tissue swelling and inflammation, Review of the medical records provided indicate that the patient was prescribed Meloxicam from 09/19/14 through 03/26/15. However, the treater does not document how this medication has been effective in management of pain and function. 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. Due to lack of documentation, the request IS NOT medically necessary.

Protonix 20mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 69.

Decision rationale: The patient presents with pain in the right shoulder. The request is for PROTONIX 20 MG #30. Patient is status post right shoulder arthroscopic repair surgeries, 10/2011 and 04/2012, Physical examination to the right shoulder on 09/19/14 revealed tenderness to palpation in the region of the rotator cuff insertion. Range of motion was limited with flexion and lateral abduction. Impingement, Hawkins and drop arm tests were positive.

Patient's treatments have included physical therapy, medication and cortisone injections. Per 06/22/15 Request for Authorization Form, patient's diagnosis includes RTC impingement. Patient's medications, per 03/26/15 progress report include Meloxicam, Protonix, Hydrocodone, Ultram, and Terocin Patch. Per 02/12/15 report, patient is to remain off-work. MTUS Chronic Pain Medical Treatment Guidelines pg. 69 states "NSAIDs - Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI. PPI's are also allowed for prophylactic use along with NSAIDS, with proper GI assessment, such as age greater than 65, concurrent use of oral anticoagulants, ASA, high dose of NSAIDs, or history of peptic ulcer disease, etc." In regard to the request for Protonix, the treater has not included GI assessment or complaints of GI upset to substantiate such a medication. Patient has received prescriptions for Protonix, along with Meloxicam from 09/19/14 through 03/26/15. However, there is no discussion of gastric complaints or evidence of prior GI symptom relief owing to PPI utilization. Without an appropriate GI assessment or evidence of dyspepsia secondary to NSAID utilization, this medication cannot be substantiated. Therefore, the request IS NOT medically necessary.

Hydrocodone 10/325mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain CRITERIA FOR USE OF OPIOIDS Page(s): 60,61, 76-78, 88,89.

Decision rationale: The patient presents with pain in the right shoulder. The request is for HYDROCODONE 10/325 MG 60. Patient is status post right shoulder arthroscopic repair surgeries, 10/2011 and 04/2012, Physical examination to the right shoulder on 09/19/14 revealed tenderness to palpation in the region of the rotator cuff insertion. Range of motion was limited with flexion and lateral abduction. Impingement, Hawkins and drop arm tests were positive. Patient's treatments have included physical therapy, medication and cortisone injections. Per 06/22/15 Request for Authorization Form, patient's diagnosis includes RTC impingement. Patient's medications, per 03/26/15 progress report include Meloxicam, Protonix, Hydrocodone, Ultram, and Terocin Patch. Per 02/12/15 report, patient is to remain off-work. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse 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 medication to work and duration of pain relief. MTUS p77 states, "Function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." Pages 80,81 of MTUS also states "There are virtually no studies of opioids for treatment of chronic lumbar root pain with resultant radiculopathy," and for chronic back pain, it "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited." MTUS p90 maximum dose for Hydrocodone, 60mg/day. The treater does not specifically discuss this request. The progress reports from 09/19/15 through 03/26/15 all list Hydrocodone but do not adequately discuss its impact on the patient's pain and function. No before and after pain scales are used for analgesia although there is a statement that there is significant

pain reduction. No ADL's are discussed showing specific functional improvement. While UDS report dated 09/22/14 is consistent with patient's medication, no adverse effect and other measures of aberrant behavior are discussed. Outcome measures are not discussed and no validated instruments are used showing functional improvement as required by MTUS. Given the lack of documentation, as required by the guidelines, the request IS NOT medically necessary.

Ultram ER 150mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain CRITERIA FOR USE OF OPIOIDS Page(s): 60, 61, 76-78, 88, 89.

Decision rationale: The patient presents with pain in the right shoulder. The request is for ULTRAM ER 150 MG #60. Patient is status post right shoulder arthroscopic repair surgeries, 10/2011 and 04/2012, Physical examination to the right shoulder on 09/19/14 revealed tenderness to palpation in the region of the rotator cuff insertion. Range of motion was limited with flexion and lateral abduction. Impingement, Hawkins and drop arm tests were positive. Patient's treatments have included physical therapy, medication and cortisone injections. Per 06/22/15 Request for Authorization Form, patient's diagnosis includes RTC impingement. Patient's medications, per 03/26/15 progress report include Meloxicam, Protonix, Hydrocodone, Ultram, and Terocin Patch. Per 02/12/15 report, patient is to remain off-work. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse 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 medication to work and duration of pain relief. MTUS p77 states, "Function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." Pages 80, 81 of MTUS also states "There are virtually no studies of opioids for treatment of chronic lumbar root pain with resultant radiculopathy," and for chronic back pain, it "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited." MTUS Chronic Pain Medical Treatment Guidelines for Tramadol, page 113 for Tramadol (Ultram) states: Tramadol (Ultram) is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. For more information and references, see Opioids. See also Opioids for neuropathic pain. The treater has not specifically addressed this request, Review of the medical records provided indicate that the patient was prescribed Ultram from 09/19/14 through 03/26/15. In this case, treater has not stated how Ultracet reduces pain and significantly improves patient's activities of daily living. There are no validated instruments addressing analgesia. There are no specific discussions regarding aberrant behavior, adverse reactions, ADLs, etc. While UDS report dated 09/22/14 is consistent with patient's medication, no adverse effect and other measures of aberrant behavior are discussed. MTUS requires appropriate discussion of the 4A's.

Given the lack of documentation as required by guidelines, the request IS NOT medically necessary.

Terocin Cream and patches: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine Page(s): 112.

Decision rationale: The patient presents with pain in the right shoulder. The request is for TEROGIN CREAM AND PATCHES. Patient is status post right shoulder arthroscopic repair surgeries, 10/2011 and 04/2012, Physical examination to the right shoulder on 09/19/14 revealed tenderness to palpation in the region of the rotator cuff insertion. Range of motion was limited with flexion and lateral abduction. Impingement, Hawkins and drop arm tests were positive. Patient's treatments have included physical therapy, medication and cortisone injections. Per 06/22/15 Request For Authorization Form, patient's diagnosis includes RTC impingement. Patient's medications, per 03/26/15 progress report include Meloxicam, Protonix, Hydrocodone, Ultram, and Terocin Patch. Per 02/12/15 report, patient is to remain off-work. MTUS Chronic Pain Medical Treatment guidelines, page 112 under Lidocaine Indication: topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy - tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica. Page 112 also states, Lidocaine indication: neuropathic pain. Recommended for localized peripheral pain, ODG Pain chapter, under Lidoderm -Lidocaine patch- specifies that Lidoderm patches are indicated as a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. The treater has specifically discussed this request. In review of the medical records provided, the patient received prescriptions for Terocin Patches from 09/19/14 and 03/26/15. The patient is status post right shoulder rotator cuff repair surgeries and suffers with pain in the right shoulder, for which this medication would be indicated. However, treater does not discuss how it is used, how often and with what efficacy in terms of pain reduction and functional improvement. MTUS page 60 require recording of pain and function when medications are used for chronic pain. The request is not in accordance with guideline indications. Therefore, the request IS NOT medically necessary.

Ketorolac DMSO gel: Upheld

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

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

Decision rationale: The patient presents with pain in the right shoulder. The request are for KETOROLAC DMSO GEL. Patient is status post right shoulder arthroscopic repair surgeries, 10/2011 and 04/2012, Physical examination to the right shoulder on 09/19/14 revealed tenderness to palpation in the region of the rotator cuff insertion. Range of motion

was limited with flexion and lateral abduction. Impingement, Hawkins and drop arm tests were positive. Patient's treatments have included physical therapy, medication and cortisone injections. Per 06/22/15 Request for Authorization Form, patient's diagnosis includes RTC impingement. Patient's medications, per 03/26/15 progress report include Meloxicam, Protonix, Hydrocodone, Ultram, and Terocin Patch. Per 02/12/15 report, patient is to remain off-work. MTUS page 111 of the chronic pain section states the following regarding topical analgesics: Largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents. Topical NSAIDs are indicated for peripheral joint arthritis/tendinitis, MTUS page 29 guidelines state that Flurbiprofen topical is recommended only as an option in patients who have not responded or are intolerant to other treatments. Indications are osteoarthritis, fibromyalgia, chronic non-specific back pain and it is also helpful for chronic neuropathic and musculoskeletal pain. The MTUS has the following regarding topical creams (p111, chronic pain section): There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The treater has not specifically addressed this request. Review of the medical records provided indicates that the patient was prescribed Ketorolac DSMO Gel from 09/19/14 through 12/02/14. The patient is status post right shoulder rotator cuff repair surgeries and suffers with pain in the right shoulder. Given the patient's condition, the use of this medication would be indicate. However, none of the reports discuss how this medication is used and with what efficacy. MTUS requires recording of pain and function when medications are used for chronic pain. This request does not meet guideline indications. Therefore, the request IS NOT medically necessary.