

Case Number:	CM15-0148833		
Date Assigned:	08/11/2015	Date of Injury:	10/04/2011
Decision Date:	09/15/2015	UR Denial Date:	07/27/2015
Priority:	Standard	Application Received:	07/30/2015

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 47-year-old female who sustained an industrial injury on 10-04-2011. Mechanism of injury was not found in documents presented for review. Diagnoses include sprain of the shoulder, sprain of the neck, carpal tunnel syndrome, and tenosynovitis of the hand. Treatment to date has included diagnostic studies, medications, cortisone injections, activity modifications, and application of ice. Her current medications include Pepcid and Motrin. She is working 32 hours a week with modifications. A physician progress note dated 07-15-2015 documents the injured worker complains of pain in her left shoulder rated 5-6 out of 10. She has sleeplessness twice per night due to pain. The pain is described as aching, stabbing, burning, throbbing and numbness. On examination, there is moderate tenderness of the lateral supraspinatus fossa, acromioclavicular joint, bicipital groove and tuberosity. She has limited range of motion and positive carpal, cubital and Guyon's canal testing. The treatment plan includes an arthroscopic procedure on the left shoulder on 07-24-2015. Treatment requested is for Zofran 4mg Qty: 30 with 2 refills, Restoril 30mg Qty: 30 with 2 refills, and Norco 10/325mg Qty: 60 with 2 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg Qty: 60 with 2 refills: Upheld

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

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 left shoulder pain rated 5-6/10. The request is for Norco 10/325mg qty: 60 with 2 refills. The request for authorization is dated 07/23/15. The patient is scheduled for left shoulder arthroscopic decompression, 07/24/15. X-ray of the left shoulder, 07/06/15, shows normal left shoulder. Physical examination of the left shoulder reveals moderate tenderness in the lateral supraspinatus fossa and AC joint, greatest at the bicipital groove, and moderate at the tuberosity as well as posteriorly. Carpal, cubital and Guyon's canal testing is positive. Patient's medications include Pepcid and Motrin. Per progress report dated 07/15/15, the patient is temporarily totally disabled. 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." MTUS p90 states, "Hydrocodone has a recommended maximum dose of 60mg/24hrs." Per progress report dated 07/15/15, treater reason for the request is "the patient is allergic to codeine and penicillin." This appears to be initial trial prescription for Norco. The treater's prescribed dose is, "Norco 10/325 one to two every 6 hours, not to exceed eight per day." In this case, the maximum dose is 80mg/24hrs. However, MTUS guidelines have a recommended maximum dose of 60mg/24hrs for Hydrocodone. The request does not meet MTUS guidelines indication and exceeds what is recommended. Therefore, the request IS NOT medically necessary.

Zofran 4mg Qty: 30 with 2 refills: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - TWC Pain Procedure Summary Online Version last updated 06/15/2015.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Chapter, under Antiemetics (for opioid nausea).

Decision rationale: The patient presents with left shoulder pain rated 5-6/10. The request is for Zofran 4mg qty: 30 with 2 refills. The request for authorization is dated 07/23/15. The patient is scheduled for left shoulder arthroscopic decompression, 07/24/15. X-ray of the left shoulder, 07/06/15, shows normal left shoulder. Physical examination of the left shoulder reveals moderate tenderness in the lateral supraspinatus fossa and AC joint, greatest at the bicipital groove, and moderate at the tuberosity as well as posteriorly. Carpal, cubital and Guyon's canal testing is positive. Patient's medications include Pepcid and Motrin. Per progress report dated 07/15/15, the patient is temporarily totally disabled. ODG-TWC Guidelines, Pain (Chronic) Chapter, under Antiemetics (for opioid nausea) Section states, "Not recommended for nausea and vomiting secondary to chronic opioid use. Ondansetron (Zofran): This drug is a serotonin

5- HT3 receptor antagonist. It is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA-approved for postoperative use. Acute use is FDA-approved for gastroenteritis." Per progress report dated 07/15/15, treater's reason for the request is "for nausea." This appears to be the initial trial prescription for Zofran. In this case, the patient is scheduled for left shoulder arthroscopic decompression on 07/24/15. ODG guidelines support the postoperative use of Zofran as it is FDA-approved. Therefore, the request IS medically necessary.

Restoril 30mg Qty: 30 with 2 refills: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Chapter, under Insomnia treatment Pain (Chronic) Chapter, under Benzodiazepines.

Decision rationale: The patient presents with left shoulder pain rated 5-6/10. The request is for Restoril 30mg qty: 30 with 2 refills. The request for authorization is dated 07/23/15. The patient is scheduled for left shoulder arthroscopic decompression, 07/24/15. X-ray of the left shoulder, 07/06/15, shows normal left shoulder. Physical examination of the left shoulder reveals moderate tenderness in the lateral supraspinatus fossa and AC joint, greatest at the bicipital groove, and moderate at the tuberosity as well as posteriorly. Carpal, cubital and Guyon's canal testing is positive. Patient's medications include Pepcid and Motrin. Per progress report dated 07/15/15, the patient is temporarily totally disabled. ODG-TWC Guidelines, Pain (Chronic) Chapter, under Insomnia treatment Section states, "FDA-approved benzodiazepines for sleep maintenance insomnia include temazepam (Restoril). These medications are only recommended for short-term use due to risk of tolerance, dependence, and adverse events. Particular concern is noted for patients at risk for abuse or addiction. Benzodiazepines are similar in efficacy to benzodiazepine-receptor agonists; however, the less desirable side-effect profile limits their use as a first-line agent, particularly for long-term use." ODG-TWC Guidelines, Pain (Chronic) Chapter, under Benzodiazepines Section states, "Not recommended for long-term use (longer than two weeks), because long-term efficacy is unproven and there is a risk of psychological and physical dependence or frank addiction. Most guidelines limit use to 4 weeks." Per progress report dated 07/15/15, treater's reason for the request is for "sleep to allow for nocturnal rest following the procedure." This appears to be the initial trial prescription for Restoril. In this case, treater's prescribed dose is, "Restoril 30 mg one p. o. q. h. s. p. r. n." However, ODG only recommends benzodiazepines for short-term use, limited to 4 weeks, due to risk of tolerance, dependence, adverse events and side-effect profile. The request for Restoril #30 with 2 refills does not indicate short-term use and exceeds what is recommended by ODG guidelines. Therefore, the request IS NOT medically necessary.

