

Case Number:	CM15-0183927		
Date Assigned:	09/24/2015	Date of Injury:	07/08/2012
Decision Date:	11/19/2015	UR Denial Date:	08/20/2015
Priority:	Standard	Application Received:	09/18/2015

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, Pain Management

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 38 year old male who sustained an industrial injury on 07-08-2012. The injured worker was diagnosed with shoulder strain, shoulder impingement syndrome, rotator cuff tendonitis-bursitis, high-grade partial thickness rotator cuff tear, and biceps tendinopathy with partial tear, superior labral anterior posterior (SLAP) lesion and Bankart lesion with instability. The injured worker is status post right shoulder arthroscopy with capsulorrhaphy in July 2014 and right shoulder arthroscopy with biceps tenotomy, debridement and lysis of adhesions approximately on May 29, 2015. According to the primary treating physician's progress report on 08-17-2015, the injured worker reported his right shoulder pain was improving with physical therapy and medications. Examination demonstrated tenderness to palpation at the anterior capsule and acromioclavicular joint with subacromial impingement. Painful arc of motion was noted at 90-130 degrees. Neurocirculatory status was intact. On 08-17-2015, the surgical report documented intermittent pain to the anterior shoulder and worse with lifting motion. The injured worker reported his strength was weak and range of motion was limited due to pain and documented as flexion at 150 degrees, abduction at 110 degrees and bilateral rotation at 90 degrees each. Grip strength was 0 on the right. There was moderate tenderness to the sternoclavicular, acromioclavicular joint, glenohumeral, biceps tendon and the subacromial area. The injured worker has 3 more sessions of physical therapy and is taking 4-6 Percocet per day. Opioids have been used at least since the first surgical intervention in July 2014. Prior treatments included diagnostic testing, surgery, physical therapy, right shoulder cortisone injections, home exercise program and medications. Current medication was listed as

Percocet. The injured worker remains on temporary total disability (TTD) with no modified duties available. Treatment plan consists of continuing medication regimen, continuing temporary modified work pending re-evaluation and the current request for Percocet 10/325mg #60, Nizatidine 150mg #60 with 2 refills, Orphenadrine 100mg #60 with 2 refills and Neurontin 600mg #60 with 2 refills. On 08-20-2015, the Utilization Review determined the request for Percocet 10/325mg #60, Nizatidine 150mg #60 with 2 refills, Orphenadrine 100mg #60 with 2 refills and Neurontin 600mg #60 with 2 refills were not certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurontin 600 MG #60 with 2 Refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Anti-epilepsy drugs (AEDs).

Decision rationale: Regarding request for gabapentin, Chronic Pain Medical Treatment Guidelines state that anti-epilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is no identification of any specific analgesic benefit (in terms of percent reduction in pain or reduction of NRS), and no documentation of specific objective functional improvement. Additionally, there is no discussion regarding side effects from this medication. In the absence of such documentation, the current request is not medically necessary.

Orphenadrine 100 MG #60 with 2 Refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: Regarding the request for orphenadrine (Norflex), Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the orphenadrine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. Given this, the currently requested orphenadrine (Norflex) is not medically necessary.

Nizatidine 150 MG #60 with 2 Refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: Regarding the request for nizatidine (Axid), California MTUS states that H2 receptor antagonists are appropriate for the treatment of dyspepsia secondary to NSAID therapy. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use or another indication for this medication. In light of the above issues, the currently requested nizatidine (Axid) is not medically necessary.

Percocet 10/325 MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: Regarding the request for Percocet (oxycodone/acetaminophen), Chronic Pain Medical Treatment Guidelines state that Percocet is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, the patient was previously using Norco without documented treatment failure. Additionally, there is no indication that Percocet is improving the patient's function or pain, no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Percocet (oxycodone/acetaminophen) is not medically necessary.