

Case Number:	CM15-0021242		
Date Assigned:	02/10/2015	Date of Injury:	07/24/2013
Decision Date:	03/30/2015	UR Denial Date:	01/16/2015
Priority:	Standard	Application Received:	02/03/2015

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: Pennsylvania

Certification(s)/Specialty: Internal Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 53 year old male sustained an industrial injury on 7/24/13, with subsequent ongoing left shoulder, bilateral forearm, hand and wrist pain. Diagnoses include left shoulder impingement syndrome, rotator cuff tear, and right greater than left radial tunnel syndrome. Magnetic resonance imaging left shoulder (1/18/14) showed a high grade partial thickness tear of the anterior fibers of the distal supraspinatus tendon. On 6/9/14, the injured worker underwent left shoulder subacromial decompression with debridement of rotator cuff tear, partial distal claviclectomy/Mumford procedure and synovectomy-bursectomy. Treatment has included surgery, medications, TENS unit, physical therapy, and home exercise program. Progress notes from April to December 2014 were submitted. Medications in June of 2014 included tramadol and hydrocodone, medications in July of 2014 included hydrocodone, naproxen, and pantoprazole. At an office visit on 10/31/14, the physician documented that medication with hydrocodone and nonsteroidal anti-inflammatory medication (NSAID) at the current dosing regime allowed the injured worker to maintain activities of daily living (ADLs) including grocery shopping basic household duties, grooming, and preparation of food, as well as greater range of motion and improved tolerance to exercise and activity. The physician documented that NSAID therapy resulted in gastrointestinal (GI) upset but with proton pump inhibitor (PPI) at three times daily dosing he denied GI upset, and that omeprazole was not efficacious but that pantoprazole has eliminated adverse GI effects. Cyclobenzaprine was prescribed for muscle spasm. The physician documented that there was no history of ulcer, hemoptysis, or hemochezia. In a PR-2 dated 12/12/14, the injured worker complained of left shoulder, bilateral

forearm, wrist and hand pain 5-6/10 on the visual analog scale. The injured worker could complete activities of daily living with current medication regimen. Physical exam was remarkable for tenderness to palpation to left shoulder with limited range of motion, unchanged bilateral forearm and left wrist exam with positive Tinel's and Phalen's test bilaterally and diminished sensation at the median nerve distribution. Current diagnoses included status post left shoulder arthroscopy, bilateral radial tunnel syndrome and rule out median neuropathy. Medications as of 12/12/14 were hydrocodone, naproxen, cyclobenzaprine, and pantoprazole. Shoulder pain was rated at 5 out of 10 in severity from October through December 2014. The documentation at office visits includes discussion of urine drug screens performed approximately monthly at the office visits which were consistent with prescribed medications, and discussion of narcotic analgesic monitoring. Work status from April through December 2014 was noted to be temporarily totally disabled. On 1/16/15, Utilization Review modified a request for Naproxen 550mg #60 With 1 Refill to Naproxen 550mg #60 With 0 Refills and Pantoprazole 20mg #60 With 1 Refill to Pantoprazole 20mg #60 With 0 Refills. Utilization Review noncertified a request for Norco 10/325gm #60, Hydrocodone 10/325gm #60, Cyclobenzaprine 7.5mg #90, Cyclobenzaprine 10mg #60 with 1 Refill and one urine drug screen citing CA MTUS Chronic Pain Medical Treatment Guidelines. The decision was subsequently appealed to Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription of Naproxen 550mg #60 With 1 Refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): p. 67-73.

Decision rationale: Per the MTUS, nonsteroidal anti-inflammatory drugs (NSAIDs) are recommended as a second line treatment after acetaminophen for treatment of acute exacerbations of chronic back pain, and for treatment of osteoarthritis. NSAIDs are noted to have adverse effects including gastrointestinal side effects and increased cardiovascular risk; besides these well-documented side effects of NSAIDs, NSAIDs have been shown to possibly delay and hamper healing in all the soft tissues including muscles, ligaments, tendons, and cartilage. NSAIDs can increase blood pressure and may cause fluid retention, edema, and congestive heart failure; all NSAIDs are relatively contraindicated in patients with renal insufficiency, congestive heart failure, or volume excess. They are recommended at the lowest dose for the shortest possible period in patients with moderate to severe pain. Systemic toxicity is possible with NSAIDs. The FDA and MTUS recommend monitoring of blood tests and blood pressure. There is no evidence that the prescribing physician is adequately monitoring for toxicity as recommended by the FDA and MTUS. Naproxen has been prescribed for at least 6 months without documentation of monitoring of blood pressure or laboratory tests. There was no documentation of functional improvement as a result of naproxen use. Although the physician documented maintenance of activities of daily living as a result of medications, no improvement

in specific activities of daily living were documented, work status remained temporarily totally disabled, office visits continued at the same frequency, and medication use was not reduced. Due to long term use not in accordance with the guidelines, lack of demonstration of functional improvement, and potential for toxicity, the request for naproxen is not medically necessary.

1 Prescription of Pantoprazole 20mg #60 With 1 Refill: 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 risk p. 68 Page(s): p. 68.

Decision rationale: Co-therapy with a nonsteroidal anti-inflammatory medication (NSAID) and a proton pump inhibitor (PPI) is not indicated in patients other than those at intermediate or high risk for gastrointestinal events (including age > 65 years, history of peptic ulcer, gastrointestinal (GI) bleeding or perforation, concurrent use of aspirin, corticosteroids and/or an anticoagulant, or high dose/multiple NSAIDS such as NSAID plus low dose aspirin). Long term proton pump inhibitor (PPI) use (> 1 year) has been shown to increase the risk of hip fracture. The documentation notes that the injured worker was prescribed naproxen, a NSAID, and pantoprazole, a PPI. The documentation indicates that NSAID therapy resulted in GI upset which was eliminated with pantoprazole. Omeprazole was determined to be not efficacious. The physician documented that there was no history of ulcer, hemoptysis, or hematochezia. The injured worker did not have intermediate or high risk of GI events per criteria noted above. No other GI issues or symptoms were discussed. In addition, the associated NSAID has been determined to be not medically necessary. Due to lack of indication, the request for pantoprazole is not medically necessary.

1 Prescription of Norco 10/325gm #60: 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): p. 74-96.

Decision rationale: There is no evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. There should be a prior failure of non-opioid therapy. None of these aspects of prescribing are in evidence. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, and "mechanical and compressive etiologies." There is no evidence of significant pain relief or increased function from the opioids used to date. There was no documentation of functional improvement as a result of opioid use. Although the physician documented maintenance of activities of daily living as a result of medications, no improvement in specific activities of daily living were documented, work status remained temporarily totally disabled, office visits

continued at the same frequency, and medication use was not reduced. Shoulder pain continued to be rated at 5 out of 10 in severity. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient "has failed a trial of non-opioid analgesics." Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The physician did document monitoring for these "4 A's" representing the domains of monitoring. The MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. The documentation notes multiple urine drug screens as consistent with prescribed medications; however these drug screens were collected at office visits and not randomly as recommended by the guidelines. Norco contains hydrocodone and acetaminophen. The request for medications also contained a separate request for hydrocodone, which is duplicative and potentially toxic. As currently prescribed, Norco does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

1 Prescription of Hydrocodone 10/325gm #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids
Page(s): p. 74-96.

Decision rationale: There is no evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. There should be a prior failure of non-opioid therapy. None of these aspects of prescribing are in evidence. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, and "mechanical and compressive etiologies." There is no evidence of significant pain relief or increased function from the opioids used to date. There was no documentation of functional improvement as a result of opioid use. Although the physician documented maintenance of activities of daily living as a result of medications, no improvement in specific activities of daily living were documented, work status remained temporarily totally disabled, office visits continued at the same frequency, and medication use was not reduced. Shoulder pain continued to be rated at 5 out of 10 in severity. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient "has failed a trial of non-opioid analgesics." Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The physician did document monitoring for these "4 A's" representing the domains of monitoring. The MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. The documentation notes multiple urine drug screens as consistent with prescribed medications; however these drug screens were collected at office visits and not randomly as recommended by the guidelines. The request for medications also contained a separate request for Norco, which contains hydrocodone, which is duplicative and potentially toxic. As currently prescribed, hydrocodone does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

1 Prescription of Cyclobenzaprine 7.5mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines cyclobenzaprine p. 41-42 muscle relaxants p. 63-66 Page(s): 41-42, 63-66.

Decision rationale: The MTUS for chronic pain does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short-term use only. The muscle relaxant prescribed in this case is sedating. The injured worker has chronic pain with no evidence of prescribing for flare-ups. The quantity prescribed implies long term use, not for a short period of use for acute pain. The injured worker was prescribed cyclobenzaprine for more than one month for muscle spasm. No reports show any specific and significant improvement in pain or function as a result of prescribing muscle relaxants. Per the MTUS chronic pain medical treatment guidelines, cyclobenzaprine (Flexeril, fexmid) is a skeletal muscle relaxant and a central nervous system depressant. It is recommended as an option for a short course of therapy, with greatest effect in the first four days of treatment. Guidelines state that treatment should be brief. The addition of cyclobenzaprine to other agents is not recommended. Limited, mixed evidence does not allow for a recommendation for chronic use. The request for medications also contains a separate request for cyclobenzaprine 10 mg, which is duplicative and potentially toxic. Due to length of use not in accordance with the guidelines, the request for cyclobenzaprine 7.5 mg is not medically necessary.

1 Prescription of Cyclobenzaprine 10mg #60 with 1 Refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines cyclobenzaprine p. 41-42 muscle relaxants p. 63-66 Page(s): 41-42, 63-66.

Decision rationale: The MTUS for chronic pain does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short-term use only. The muscle relaxant prescribed in this case is sedating. The injured worker has chronic pain with no evidence of prescribing for flare-ups. The quantity prescribed implies long term use, not for a short period of use for acute pain. The injured worker was prescribed cyclobenzaprine for more than one month for muscle spasm. No reports show any specific and significant improvement in pain or function as a result of prescribing muscle relaxants. Per the MTUS chronic pain medical treatment guidelines, cyclobenzaprine (Flexeril, fexmid) is a skeletal muscle relaxant and a central nervous system depressant. It is recommended as an option for a short course of therapy, with greatest effect in the first four days of treatment. Guidelines state that treatment should be brief. The addition of cyclobenzaprine to other agents is not recommended. Limited, mixed evidence does not allow for a recommendation for chronic use. The request for medications also contains a separate request for cyclobenzaprine 7.5 mg mg, which is duplicative and potentially

toxic. Due to length of use not in accordance with the guidelines, the request for cyclobenzaprine 10 mg is not medically necessary.

1 Urine Drug Screen: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines drug testing p. 43, opioids p. 77- 78, p. 89, p. 94 Page(s): p. 43, 77-78, 89, 94. Decision based on Non-MTUS Citation chronic pain chapter: urine drug testing

Decision rationale: Per MTUS chronic pain medical treatment guidelines, urine drug screens are recommended as an option to assess for the use or the presence of illegal drugs, in accordance with a treatment plan for use of opioid medication, and as a part of a pain treatment agreement for opioids. Per the ODG, urine drug testing is recommended as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances. Urine drug testing is recommended at the onset of treatment when chronic opioid management is considered, if the patient is considered to be at risk on addiction screening, or if aberrant behavior or misuse is suspected or detected. Ongoing monitoring is recommended if a patient has evidence of high risk of addiction and with certain clinical circumstances. Frequency of urine drug testing should be based on risk stratification. Patients with low risk of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. Patients at moderate risk for addiction/aberrant behavior should be tested 2-3 times per year. Patients at high risk of adverse outcomes may require testing as often as once a month. Random collection is recommended. Results of testing should be documented and addressed. The physician documented that this injured worker was at high risk of aberrant behavior and therefore required monthly urine drug screens. Multiple urine drug screens obtained at office visits were noted to be consistent with prescribed medications. The collections were performed at the time of the office visits and not randomly as per the guidelines. The associated opioid medication has been determined to be not medically necessary. As the continued use of opioids has been determined to be not medically necessary, the request for 1 urine drug screen is not medically necessary.