

Case Number:	CM14-0113436		
Date Assigned:	08/01/2014	Date of Injury:	02/13/2003
Decision Date:	09/29/2014	UR Denial Date:	07/03/2014
Priority:	Standard	Application Received:	07/21/2014

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 Family Medicine 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:

This is a 64-year-old female patient who reported an industrial injury on 2/13/2003, over 11 years ago, attributed to the performance of her customary work tasks. The patient complains of chronic shoulder pain along with numbness over the fourth and fifth right finger. There were no objective findings on examination documented by the requesting physician. There only vital signs documented. The diagnoses included pain in the joint of the shoulder and rotator cuff disorders not elsewhere classified. The patient was being prescribed fentanyl 25 mcg/hr #10; Norco 10/325 mg #60; Medroxcin patches; Soma 350 mg #60 and a MRI of the right shoulder without contrast.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the right shoulder without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 29. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder-MRI.

Decision rationale: The request for a MRI of the right shoulder was not supported with any objective evidence on physical examination and was not demonstrated to be medically necessary. No rationale for a MRI study of the right shoulder was documented, as there were no objective findings on examination included. There were no objective findings documented on examination to the Right shoulder to meet the requirements recommended by the ACOEM Guidelines, or ODG for a MRI of the shoulder. There was no demonstrated intention of surgical intervention and the request is made as a screening study to rule out internal derangement. There were no documented objective findings consistent with internal derangement of the right shoulder. The patient has not met the criteria or period of treatment with conservative care recommended by evidence-based guidelines. There was no noted internal derangement to the Right shoulder and the diagnosis was a shoulder strain. The request for the MRI is not made by a surgeon contemplating surgical intervention to the shoulder. There were no current documented objective findings or diagnosis of rotator cuff tear or internal derangement as the request appeared as a screening study. The documented objective findings on examination dated were limited with no findings consistent with internal derangement. The MRI of the Right shoulder is not demonstrated to be medically necessary and has not met the criteria recommended by the ACOEM Guidelines, or the Official Disability Guidelines. The Right shoulder MRI is not supported with a rationale other than a screening study. The provider wishes to evaluate the shoulder for a possible tear; however, there are no objective findings on examination that have either changed or demonstrate possible internal derangement documented for the Right shoulder. The symptoms and objective findings documented are minimal and there is no consideration of surgical intervention to the shoulder. The patient has not been demonstrated to have failed conservative treatment prior to the authorization of a MRI of the shoulder. The provider has not established or documented subjective/objective changes to the physical examination of the right shoulder that meets the recommendations of the CA MTUS, ACOEM Guidelines, or the Official Disability Guidelines for the authorization of shoulder MRIs. There are no demonstrated changes in clinical status related to the shoulder that would support the medical necessity of the right shoulder MRI with anticipation of surgical intervention at this point in time without continued conservative treatment. The patient is not documented to be participating in a self-directed home exercise program. Therefore, the request is not medically necessary.

Soma 350mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 74.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines antispasticity/antispasmodic drugs Page(s): 66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter--muscle relaxants and Carisoprodol.

Decision rationale: The patient is prescribed Carisoprodol/SOMA 350 mg #60 on a routine basis for the treatment of chronic pain and is not directed to muscle spasms on a prn basis. The CA MTUS does not recommend the prescription of Carisoprodol. There is no medical necessity for the prescribed Soma 350 mg #60 for chronic pain or muscle spasms, as it is not recommended by evidence-based guidelines. The prescription of Carisoprodol is not

recommended by the CA MTUS for the treatment of injured workers. The prescription of Carisoprodol as a muscle relaxant is not demonstrated to be medically necessary for the treatment of the chronic back pain on a routine basis. The patient has been prescribed Carisoprodol on a routine basis for muscle spasms. There is no demonstrated medical necessity for the daily prescription of Carisoprodol as a muscle relaxer on a daily basis for chronic pain. The prescription of Carisoprodol for use of a muscle relaxant for cited chronic pain is inconsistent with the recommendations of the CA MTUS, the ACOEM Guidelines, and the Official Disability Guidelines. The use of alternative muscle relaxants was recommended by the CA MTUS and the Official Disability Guidelines for the short-term treatment of chronic pain with muscle spasms; however, muscle relaxants when used are for short-term use for acute pain and are not demonstrated to be effective in the treatment of chronic pain. The use of Carisoprodol is associated with abuse and significant side effects related to the psychotropic properties of the medication. The centrally acting effects are not limited to muscle relaxation. The prescription of Carisoprodol as a muscle relaxant is not recommended as others muscle relaxants that without psychotropic effects are readily available. There is no medical necessity for Carisoprodol 350 mg #60. There are clearly no recommendations for the prescribed combination of Valium and Carisoprodol due to the psychotropic effects. The California MTUS guidelines state that Carisoprodol is not recommended. This medication is not indicated for long-term use. Carisoprodol is a commonly prescribed centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate a schedule for controlled substance. It has been suggested that the main effect is due to generalize sedation and treatment of anxiety. Abuses been noted for sedative and relaxant effects. In regular abusers, the main concern is for the accumulation of meprobamate. Carisoprodol abuses also been noted in order to augment or alter effects of other drugs. This includes the following increasing sedation of benzodiazepines or alcohol; used to prevent side effects of cocaine; use with tramadol to ghost relaxation and euphoria; as a combination with hydrocodone as an effective some abuses claim is similar to heroin referred to as a Las Vegas cocktail; and as a combination with codeine referred to as Carisoprodol Coma. There is no documented functional improvement with the use of the prescribed Carisoprodol. The use of Carisoprodol/Soma is not recommended due to the well-known psychotropic properties. Therefore, the request is not medically necessary.

Fentanyl 25mcg # 10: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-306, Chronic Pain Treatment Guidelines OPIOIDS Page(s): 74-97. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) chapter 6 pages 114-116 Official Disability Guidelines (ODG) pain chapter opioids.

Decision rationale: There has been no attempt to titrate the patient down from the high dose of opioids prescribed even though evidence-based guidelines established that the high dose opioids therapy was not medically necessary for the diagnoses cited. It is noted that the daily MED is actually increasing. The prescription for Fentanyl patches 25 mcg/hr #10 for pain is being

prescribed as an opioid analgesic for the treatment of chronic shoulder pain. There is objective evidence provided to support the continued prescription of opioid analgesics for chronic shoulder pain based on the objective findings documented. There is no documented sustained significant functional improvement with the currently prescribed Fentanyl patches. The chronic use of Fentanyl patches is not recommended by the CA MTUS, the ACOEM Guidelines, or the Official Disability Guidelines for the long-term treatment of chronic shoulder pain. The updated chapter of the ACOEM Guidelines and the third edition of the ACOEM Guidelines stated that both function and pain must improve to continue the use of opioids. The prescription of opiates on a continued long-term basis is inconsistent with the CA MTUS and the Official Disability Guidelines recommendations for the use of opiate medications for the treatment of chronic pain. There is objective evidence that supports the use of opioid analgesics in the treatment of this patient over the use of NSAIDs and OTC analgesics for the treatment of chronic shoulder pain. Evidence-based guidelines necessitate documentation that the patient has signed an appropriate pain contract, functional expectations have been agreed to by the clinician, and the patient, pain medications will be provided by one physician only, and the patient agrees to use only those medications recommended or agreed to by the clinician to support the medical necessity of treatment with opioids. The ACOEM Guidelines updated chapter on chronic pain states, "Opiates for the treatment of mechanical and compressive etiologies: rarely beneficial. Chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs (as suggested by the WHO step-wise algorithm). When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs. A major concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period (70 days). This leads to a concern about confounding issues; such as, tolerance, opioid-induced hyperalgesia, long-range adverse effects, such as, hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment effect." ACOEM guidelines state that opioids appear to be no more effective than safer analgesics for managing most musculoskeletal and eye symptoms; they should be used only if needed for severe pain and only for a short time. The long-term use of opioid medications may be considered in the treatment of chronic musculoskeletal pain, if: The patient has signed an appropriate pain contract; Functional expectations have been agreed to by the clinician and the patient; Pain medications will be provided by one physician only; The patient agrees to use only those medications recommended or agreed to by the clinician. ACOEM also notes, "Pain medications are typically not useful in the subacute and chronic phases and have been shown to be the most important factor impeding recovery of function." Evidence-based guidelines recommend: Chronic back pain: Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. There is no evidence to recommend one opioid over another. In patients taking opioids for back pain, the prevalence of lifetime substance use disorders has ranged from 36% to 56% (a statistic limited by poor study design). Limited information indicated that up to one-fourth of patients who receive opioids exhibit aberrant medication-taking behavior. The ODG states, chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs (as suggested by the WHO step-wise algorithm). When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe

pain may be added to (not substituted for) the less efficacious drugs. A major concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period (70 days). This leads to a concern about confounding issues; such as, tolerance, opioid-induced hyperalgesia, long-range adverse effects, such as, hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment effect (Ballantyne, 2006) (Furlan, 2006), long-term, observational studies have found that treatment with opioids tends to provide improvement in function and minimal risk of addiction, but many of these studies include a high dropout rate (56% in a 2004 meta-analysis) (Kalso, 2004). There is also no evidence that opioids showed long-term benefit or improvement in function when used as treatment for chronic back pain (Martell-Annals, 2007) (ODG, Pain Chapter). There is no clinical documentation with objective findings on examination to support the medical necessity of Fentanyl patches for the treatment of chronic shoulder pain. There is no provided evidence that the patient has received benefit or demonstrated functional improvement with Fentanyl patches. There is no demonstrated medical necessity for the prescribed Opioids over a prolonged period of time for the cited diagnoses.