

Case Number:	CM14-0115880		
Date Assigned:	08/04/2014	Date of Injury:	05/03/1997
Decision Date:	10/16/2014	UR Denial Date:	07/11/2014
Priority:	Standard	Application Received:	07/23/2014

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 Physical Medicine and Rehabilitation, and is licensed to practice in Nevada. 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:

The records presented for review indicate that this 64 year-old male was reportedly injured on May 3, 1997. The mechanism of injury is noted as a fall. The most recent progress note, dated June 25, 2014 indicates that there were ongoing complaints of right shoulder pain, poor sleep, and activity limitations. The physical examination demonstrated restricted range of motion of the shoulders with a positive Neer and Hawkins tests on the right. Tenderness to palpation on the right was noted with diminished sensation of the right middle finger. Diagnostic imaging studies have included an MRI in August 2007, with evidence of a recurrence supraspinatus tear. An MRI of the right shoulder in 2006 was also obtained. The most recent MRI findings are not reported in detail. Prior treatment has included right shoulder arthroscopy in 2006, pharmacotherapy, TENS therapy, and activity modification. A request had been made for 200 tablets of OxyContin 20 mg, 30 tablets of Silenor, and 30 tablets of Celebrex 200 mg and was not certified in the pre-authorization process on July 11, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin 20mg tablet #135: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-82.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

Decision rationale: CA MTUS guidelines require ongoing review and documentation evidencing pain relief, improvement in functional status, appropriate medication use, and review of side effects. The medical record also indicates that the claimant has been utilizing OxyContin opioid therapy since March. The most recent progress note indicates that the claimant's pain is reduced from 7-8/10 to 4-5/10, and at times 2/10 with the use of this medication. Additionally, the ability to perform ADLs such as grocery shopping, and household chores is also documented. A CURES report is noted, adverse effects are documented, and evidence of a urine drug screen protocol is noted in this progress report. Based on the medical record provided for review, the required documentation and reassessment with the use of chronic opioid pain medication has been noted that would fall within the guideline recommendations for the use of this medication in the management of chronic pain. As such, this request is considered medically necessary, and reversal of the prior UR decision is recommended.

Silenor 3mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th edition (web), 2013, Chronic Pain Chapter, Insomnia Treatment

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122.

Decision rationale: The MTUS supports the use of tricyclic antidepressants in chronic pain management for neuropathic and possibly non-neuropathic pain. However, the medical record indicates that this medication is being utilized for the treatment of insomnia. The MTUS/ACOEM practice guidelines do not address the use of this medication for the treatment of insomnia. Therefore, ODG guidelines are used. The ODG guidelines recognize that this class of medication is sometimes used for insomnia, noting a lack of sufficient evidence to support their use, but recognizing that this medication, may be an option in patients with coexisting depression. The progress note, submitted in support of this request makes no reference to a diagnosis of depression. When recognizing that sleep deprivation is oftentimes secondary to pain, a recommendation would be made for clarification of the underlying diagnosis for which this medication is intended. Based on the record available, noting its use is specifically for the treatment of insomnia, this request would not be considered medically necessary.

Celebrex 200mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22, 30, 70.

Decision rationale: MTUS guidelines support the use of Celebrex in select clinical settings of acute and chronic pain in conditions for which NSAIDs are recommended, but there is a significant risk of GI complications. Review of the available medical records, reports chronic pain since 1997 but fails to document any risk or signs/symptoms of GI complications. Given the lack of clinical documentation to justify deviation from the guidelines, this request is not considered medically necessary.