MAXIMUS Federal Services

Case Number:	CM14-0152236		
Date Assigned:	09/22/2014	Date of Injury:	06/13/2012
Decision Date:	10/29/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	09/18/2014

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 & Rehabilitation and is licensed to practice in Texas & Ohio. 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 injured worker is a 49-year-old female who reported an injury on 06/13/2012. The mechanism of injury was not provided. Diagnoses included osteoarthritis of the right shoulder, acromioclavicular joint osteoarthritis of the right shoulder, and severe tendinosis of the biceps tendon of the right shoulder. Past treatments included TENS and medications. Pertinent diagnostic studies were not provided. Surgical history included right shoulder arthroscopy debridement of labral tearing with repair of the SLAP lesion, debridement of the longitudinal biceps tendon tear, and repair of the rotator cuff tear on 08/30/2013. The clinical note dated 08/18/2014 indicated the injured worker complained of constant, stabbing pain to the right shoulder with radiating numbness and tingling in the right arm, as well as limited range of motion of the right shoulder. Physical exam revealed tenderness to palpation of the right shoulder. Current medications included Naproxen 550 mg, Omeprazole 20 mg, and Tramadol 50 mg. The treatment plan included Flurbiprofen/Omeprazole 100/10 mg, quantity 90 with 3 refills; Tramadol/Acetaminophen/Ondansetron 50/250/2 mg, quantity 90, with 3 refills, and Lunesta 1 mg, quantity 90, with 3 refills. The rationale for treatment was pain control, to decrease gastrointestinal adverse effects, and to treat insomnia. The Request for Authorization form was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen/Omeprazole 100-10 mg, QTY: 90 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (Non-Steroidal Anti-Inflammatory Drugs),. Decision based on Non-MTUS Citation http://www.accessdata.fda.gov/scripts/cder/drugsatfda/

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-69.

Decision rationale: The MTUS Chronic Pain Guidelines indicate that NSAIDs are recommended at the lowest dose for the shortest period of time in patients with moderate to severe pain due to osteoarthritis. The guidelines indicate that patients at risk for a gastrointestinal event include those over the age of 65 years; history of peptic ulcers, GI bleeding or perforation; concurrent use of aspirin, corticosteroids, and/or anticoagulants; or are on high dose/multiple NSAIDs. For patients with no risk factor and no cardiovascular disease, nonselective NSAIDs are recommended. The injured worker complained of constant stabbing right shoulder pain, with radiating numbness and tingling down the right upper extremity. The clinical note dated 07/28/2014 indicated the injured worker was previously prescribed Naproxen 550 mg, and stated that her pain was rated 6/10 with medications and 8/10 without medications. There is a lack of documentation of the efficacy of the previous NSAID, or to indicate that flurbiprofen would provide better pain relief. Additionally, there is a lack of clinical documentation to indicate that the patient had subjective gastrointestinal complaints, or was at risk for a gastrointestinal event. The request does not include the frequency for taking the medication, and 3 refills would not allow for the periodic reassessment to evaluate efficacy. Therefore, the request is not medically necessary.

Tramadol/Acetaminophen/Ondansetron 50-250-2 mg, QTY: 90 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids and NSAIDS (Non-Steroidal Anti-Inflammatory Drugs) GI (Ga. Decision based on Non-MTUS Citation http://www.accessdata.fda.gov/scripts/cder/drugsatfda/

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Ondansetron (Zofran)

Decision rationale: The MTUS Chronic Pain Guidelines indicate that four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids to include pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. The Official Disability Guidelines go on to state that Ondansetron is not recommended for nausea and vomiting secondary to chronic opioid use. The injured worker complained of constant stabbing pain to the right shoulder, with numbness and tingling radiating down the right arm. The injured worker had been taking Tramadol since at least 05/05/2014. There is a lack of clinical documentation of the efficacy of the medication, including quantified pain relief and functional improvement. There is also a lack of documentation of assessment for any nonadherent drug related behaviors through the use of

urine drug screens. Additionally, there is a lack of documentation that the injured worker had complaints of nausea or vomiting to indicate the necessity of an antiemetic. The request does not indicate the frequency for taking the requested medication, and 3 refills would not allow for the periodic reassessment of efficacy. Therefore, the request is not medically necessary.

Lunesta 1 mg, QTY: 90 with 3 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Eszopicolone (Lunesta)

Decision rationale: The Official Disability Guidelines indicate that Lunesta is not recommended for long term use, but recommended for short term use for the treatment of insomnia. The injured worker complained of constant pain in the right shoulder, but there is a lack of clinical documentation to indicate she had complaints of insomnia. Additionally, the request for 3 refills would indicate long term use and would not allow for the periodic reassessment of the efficacy of treatment. Because Lunesta is recommended for the short term treatment of insomnia, and there is a lack of subjective complaints of insomnia, the request cannot be supported at this time. Therefore, the request for Lunesta 1 mg, quantity 90 with 3 refills is not medically necessary.