

Case Number:	CM14-0219227		
Date Assigned:	01/09/2015	Date of Injury:	06/16/2000
Decision Date:	03/18/2015	UR Denial Date:	12/05/2014
Priority:	Standard	Application Received:	12/31/2014

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. 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: Preventive Medicine, Occupational 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:

The injured worker is a 45 year old male with an industrial injury dated 06/16/2000. The mechanism of injury is not documented. Prior treatments include arthroscopic synovectomy, bursectomy, coracoacromial release, Neer-type acromioplasty followed by labral repair and bicep tendon release with stabilization on 04/28/2014. On 05/29/2014 he underwent a tenolysis exploration, removal of biceps stump and anchor in biceps at the bicipital groove. Other treatments include physical therapy, MRI of right chest wall, electro diagnostic studies of upper extremities (showing diffusely decrease interference pattern in the right upper extremity) and stellate block. Physical exam of the elbow revealed 40 degrees of flexion contracture which goes to about 90 degrees. Tenderness along the biceps stump where tenodesis was done is significant. Diagnoses include impingement syndrome of the right shoulder status post decompression in 2005 but April 11, 2012 MRI of the right shoulder showed supraspinatus and infraspinatus tendinosis and interstitial tear, a small fluid collection in subscapularis bursa and superior subscapularis recess, type II separation of the acromioclavicular joint as well as a small subchondral cyst on the head of the humerus and elbow inflammation status post arthroscopy, synovectomy, removal of loose body, capsulectomy and excision along the tip of the olecranon and fenestration done previously. On 12/05/2014 Utilization Review modified the following requests: -Oxycontin 10 mg # 90 - Modified to Oxycontin 10 mg # 60 - for initiation of a taper. - Percocet 10/325 mg # 120 - Modified to Percocet 10/325 mg # 90 - for initiation of a taper. The reason cited for modification of Oxycontin and Percocet was MTUS guidelines for chronic opioid therapy require ongoing review and documentation of analgesia, function, side effects and

appropriate medication use. These are not addressed in submitted documentation. MTUS was cited. The following requests were denied: -Tramadol 150 mg # 30 - MTUS guidelines for chronic opioid therapy require ongoing review and documentation of analgesia, function, side effects, and appropriate medication use. These are not addressed in submitted documentation. Thus, there is insufficient information to determine that tramadol is currently medically necessary. MTUS was cited. -Pantoprazole 20 mg # 60 - There is no documented trial of a first line proton pump inhibitor (omeprazole or lansoprazole). Thus pantoprazole is not shown to be medically necessary. MTUS was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin 10 mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids Page(s): 78-80, 124, 93-94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-94.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of OxyContin, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 6 months. Oxycontin 10 mg #90 is not medically necessary.

Percocet 10/325 mg # 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use of Opioids Page(s): 78-80, 124, 93-94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60.

Decision rationale: According to the MTUS in regard to medications for chronic pain, only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. A record of pain and function with the medication should be recorded. According to this citation from the MTUS, medications should not be initiated in a group fashion, and specific benefit with respect to pain and function should be documented for each medication. There is no documentation of the above criteria for either of narcotics that the patient has been taking. Percocet 10/325 mg # 120 is not medically necessary.

Pantoprazole 20 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & Cardiovascular Risk Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

Decision rationale: Protonix is a proton pump inhibitor. According to the Chronic Pain Medical Treatment Guidelines, and prior to prescribing a proton pump inhibitor, a clinician should determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID. There is no documentation that the patient has any the risk factors needed to recommend a proton pump inhibitor. Pantoprazole 20 mg #60 is not medically necessary.

Tramadol 150 mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids Page(s): 78-80, 124, 93-94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 113.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. Despite the long-term use of tramadol, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 6 months. Tramadol 150 mg #30 is not medically necessary.