

Case Number:	CM15-0110413		
Date Assigned:	06/17/2015	Date of Injury:	02/19/2013
Decision Date:	09/24/2015	UR Denial Date:	06/02/2015
Priority:	Standard	Application Received:	06/08/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 53-year-old male, who sustained an industrial injury on 2/19/2013, while employed as a custodian. He reported a fall onto his left side. The injured worker was diagnosed as having chronic myofascial pain syndrome, chronic left rotator cuff syndrome, status post left shoulder surgery, and status post left knee surgery (non-industrial). Treatment to date has included diagnostics, left shoulder surgery 8/2014, physical therapy, and medications. Currently, the injured worker complains of continued pain in his left shoulder and left knee. Also reported was left shoulder numbness. He was currently not working and was declared permanent and stationary for his left shoulder 1/2015. Exam was positive for left shoulder impingement and left knee tenderness. Left shoulder range of motion was decreased in all planes. Pain was not rated and medications were requested, including Naprosyn, Omeprazole, Flexeril, Neurontin, and Lidopro. The use of these medications was noted since at least 2/2015. Urine toxicology was also recommended. No significant changes were noted in physical exams for several months and pain levels were not consistently documented.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen 550mg 1 tablet by mouth two (2) times per day: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 13 Knee Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Page(s): 22.

Decision rationale: The patient presents on 05/04/15 with left shoulder pain rated 6/10 at rest, 9/10 during reaching and overhead work, and left knee pain rated 6/10 at rest, 8/10 with weight bearing. The patient's date of injury is 02/19/13. Patient is status post right shoulder arthroscopic surgery on 08/11/14, and status post left knee partial replacement and ACL repair in 2009. The request is for NAPROXEN 550MG 1 TABLET BY MOUTH TWO (2) TIMES PER DAY. The RFA is dated 05/20/15. Physical examination dated 05/04/15 reveals tenderness to palpation of the cervical paraspinal muscles, a well healed surgical scar on the left shoulder with limited range of motion in all planes to the affected extremity, a well healed surgical scar on the left knee with mild ACL laxity and slightly limited range of motion noted. The patient is currently prescribed Naprosyn, Omeprazole, Flexeril, Neurontin, and Lidopro cream. Patient is currently classified as permanent and stationary. MTUS Guidelines, Anti-inflammatory medications section, page 22 states: Anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. A comprehensive review of clinical trials on the efficacy and safety of drugs for the treatment of low back pain concludes that available evidence supports the effectiveness of non-selective nonsteroidal anti-inflammatory drugs (NSAIDs) in chronic LBP and of antidepressants in chronic LBP. In regard to Naproxen for this patient's chronic pain, the requesting physician has not specified an amount to be provided to the patient. An addendum addressed to the utilization reviewer, dated 06/04/15 provides evidence that this patient has experienced some relief attributed to this medication, cites the relevant guidelines for the continuation for this medication, and provides a statement regarding the necessity of continued utilization. However, the progress note and associated RFA do not clearly specify an amount of this medication to be provided to this patient. Were the request to specify an appropriate number of tablets, the recommendation would be for approval. However, the request as written does not clearly state this information and therefore cannot be substantiated. The request IS NOT medically necessary.

Omeprazole 20mg: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 69.

Decision rationale: The patient presents on 05/04/15 with left shoulder pain rated 6/10 at rest, 9/10 during reaching and overhead work, and left knee pain rated 6/10 at rest, 8/10 with weight bearing. The patient's date of injury is 02/19/13. Patient is status post right shoulder arthroscopic surgery on 08/11/14, and status post left knee partial replacement and ACL repair in 2009. The request is for OMEPRAZOLE 20MG. The RFA is dated 05/20/15. Physical examination dated 05/04/15 reveals tenderness to palpation of the cervical paraspinal muscles, a well healed surgical scar on the left shoulder with limited range of motion in all planes to the affected extremity, a well healed surgical scar on the left knee with mild ACL laxity and slightly limited range of motion noted. The patient is currently prescribed Naprosyn, Omeprazole, Flexeril, Neurontin, and Lidopro cream. Patient is currently classified as permanent and stationary. MTUS Guidelines, NSAIDs, GI symptoms & cardiovascular risk Section, page 69, under

Treatment of dyspepsia secondary to NSAID therapy states: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI. PPI's are also allowed for prophylactic use along with NSAIDS, with proper GI assessment, such as age greater than 65, concurrent use of oral anticoagulants, ASA, high dose of NSAIDs, or history of peptic ulcer disease, etc. In regard to Omeprazole for this patient's NSAID associated GI upset, the requesting physician has not specified an amount to be provided to the patient. An addendum addressed to the utilization reviewer, dated 06/04/15 provides evidence that this patient has a history of GI upset secondary to NSAID utilization, cites the relevant guidelines for the continuation for this medication, and a provides statement regarding the necessity of continued utilization. However, the progress note and associated RFA do not clearly specify an amount of this medication to be provided to this patient. Were the request to specify an appropriate number of tablets to be dispensed by the pharmacy, the recommendation would be for approval. However, the request as written does not clearly state this information, and therefore cannot be substantiated. The request IS NOT medically necessary.

Neurontin 600mg, three (3) times per day: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 13 Knee Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 18-19.

Decision rationale: The patient presents on 05/04/15 with left shoulder pain rated 6/10 at rest, 9/10 during reaching and overhead work, and left knee pain rated 6/10 at rest, 8/10 with weight bearing. The patient's date of injury is 02/19/13. Patient is status post right shoulder arthroscopic surgery on 08/11/14, and status post left knee partial replacement and ACL repair in 2009. The request is for NEURONTIN 600MG, THREE (3) TIMES PER DAY. The RFA is dated 05/20/15. Physical examination dated 05/04/15 reveals tenderness to palpation of the cervical paraspinal muscles, a well healed surgical scar on the left shoulder with limited range of motion in all planes to the affected extremity, a well healed surgical scar on the left knee with mild ACL laxity and slightly limited range of motion noted. The patient is currently prescribed Naprosyn, Omeprazole, Flexeril, Neurontin, and Lidopro cream. Patient is currently classified as permanent and stationary. MTUS Guidelines, Gabapentin section on pg 18, 19 has the following: Gabapentin (Neurontin, Gabarone, generic available) has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. In regard to Neurontin for this patient's chronic neuropathic pain, the requesting physician has not specified an amount to be provided to the patient. An addendum addressed to the utilization reviewer, dated 06/04/15 provides evidence that this patient has experienced some relief attributed to this medication, cites the relevant guidelines for the continuation for this medication, and provides a statement regarding the necessity of continued utilization. However, the progress note and associated RFA do not clearly specify an amount of this medication to be provided to this patient. Were the request to specify an appropriate number of tablets/capsules to be dispensed by the pharmacy, the recommendation would be for approval. However, the request as written does not clearly state this information, and therefore cannot be substantiated. The request IS NOT medically necessary.

Flexeril 7.5mg 2 tab by mouth, every night at bedtime, three (3) times per day: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder

Complaints, Chapter 13 Knee Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 64.

Decision rationale: The patient presents on 05/04/15 with left shoulder pain rated 6/10 at rest, 9/10 during reaching and overhead work, and left knee pain rated 6/10 at rest, 8/10 with weight bearing. The patient's date of injury is 02/19/13. Patient is status post right shoulder arthroscopic surgery on 08/11/14, and status post left knee partial replacement and ACL repair in 2009. The request is for FLEXERIL 7.5MG 2 TAB BY MOUTH, EVERY NIGHT AT BEDTIME, THREE (3) TIMES PER DAY. The RFA is dated 05/20/15. Physical examination dated 05/04/15 reveals tenderness to palpation of the cervical paraspinal muscles, a well healed surgical scar on the left shoulder with limited range of motion in all planes to the affected extremity, a well healed surgical scar on the left knee with mild ACL laxity and slightly limited range of motion noted. The patient is currently prescribed Naprosyn, Omeprazole, Flexeril, Neurontin, and Lidopro cream. Patient is currently classified as permanent and stationary. MTUS Guidelines, Cyclobenzaprine section, page 64 states: Recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system depressant with similar effects to tricyclic antidepressants (e.g. amitriptyline). This medication is not recommended to be used for longer than 2-3 weeks. In regard to Flexeril for this patient's chronic pain, the requesting physician has not specified an amount to be provided to the patient. An addendum addressed to the utilization reviewer, dated 06/04/15 provides evidence that this patient has experienced some relief attributed to this medication, cites the relevant guidelines for the continuation for this medication, and provides a statement regarding the necessity of continued utilization. However, the progress note and associated RFA do not clearly specify an amount of this medication to be provided to this patient. Furthermore, this patient has been prescribed this medication since at least 02/19/15; such prolonged use of this class of medications is not indicated per MTUS guidelines. The request IS NOT medically necessary.

Lidopro 4% ointment, 121 gram: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 13 Knee Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The patient presents on 05/04/15 with left shoulder pain rated 6/10 at rest, 9/10 during reaching and overhead work, and left knee pain rated 6/10 at rest, 8/10 with weight bearing. The patient's date of injury is 02/19/13. Patient is status post right shoulder arthroscopic surgery on 08/11/14, and status post left knee partial replacement and ACL repair in 2009. The request is for LIDOPRO 4% OINTMENT, 121 GRAM. The RFA is dated 05/20/15. Physical examination dated 05/04/15 reveals tenderness to palpation of the cervical paraspinal muscles, a well healed surgical scar on the left shoulder with limited range of motion in all planes to the affected extremity, a well healed surgical scar on the left knee with mild ACL laxity and slightly limited range of motion noted. The patient is currently prescribed Naprosyn, Omeprazole, Flexeril, Neurontin, and Lidopro cream. Patient is currently classified as permanent and stationary. LidoPro lotion contains Capsaicin, Lidocaine, Menthol, and methyl salicylate. The MTUS Topical Analgesics section, page 111 has the following: Topical Lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for

neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of Lidocaine whether creams, lotions or gels- are indicated for neuropathic pain. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In regard to Lidopro for this patient's chronic pain, this medication is not indicated for this patient's chief complaint. The RFA and request as written specifies for an ointment containing 121 grams, which unlike the associated requests provides a clearer indication of the amount to be dispensed for this patient. However, an addendum to the utilization reviewer, dated 06/04/15 states that Lidopro is "essential for controlling the inflammation and neuropathic pain in her arms and legs secondary to her myofascial pain syndrome and radiculopathy." Medications such as Lidocaine are only indicated for localized neuropathic pain. While the requesting physician feels as though this medication is appropriate, this patient presents with non-localized neuropathic pain not amenable to topical Lidocaine. Furthermore, MTUS guidelines do not support topical Lidocaine in formulations other than patches. Therefore, the request IS NOT medically necessary.

Urine Drug Screen: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 13 Knee Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, under Urine Drug Testing.

Decision rationale: The patient presents on 05/04/15 with left shoulder pain rated 6/10 at rest, 9/10 during reaching and overhead work, and left knee pain rated 6/10 at rest, 8/10 with weight bearing. The patient's date of injury is 02/19/13. Patient is status post right shoulder arthroscopic surgery on 08/11/14, and status post left knee partial replacement and ACL repair in 2009. The request is for URINE DRUG SCREEN. The RFA is dated 05/20/15. Physical examination dated 05/04/15 reveals tenderness to palpation of the cervical paraspinal muscles, a well healed surgical scar on the left shoulder with limited range of motion in all planes to the affected extremity, a well healed surgical scar on the left knee with mild ACL laxity and slightly limited range of motion noted. The patient is currently prescribed Naprosyn, Omeprazole, Flexeril, Neurontin, and Lidopro cream. Patient is currently classified as permanent and stationary. MTUS Guidelines, Drug Testing section, Page 43 has the following: Recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. For more information, see Opioids, criteria for use: (2) Steps to Take Before a Therapeutic Trial of Opioids & (4) On- Going Management; Opioids, differentiation: dependence & addiction; Opioids, screening for risk of addiction (tests); & Opioids, steps to avoid misuse/addiction. ODG Pain Chapter, under Urine Drug Testing has the following: Patients at "moderate risk" for addiction/aberrant behavior are recommended for point-of-contact screening 2 to 3 times a year with confirmatory testing for inappropriate or unexplained results. Patients at "high risk" of adverse outcomes may require testing as often as once per month. Patients at "low risk" of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. In regard to a urine drug screen, the requesting physician has not provided a reason for the request. While guidelines support such screening to confirm patient compliance with narcotic medications, this patient is not currently prescribed any medications of this class. Without a rationale as to why this patient requires urine drug screening, the intent to prescribed Opioid medications, or evidence of current opioid/narcotic medication utilization, the request cannot be substantiated. The request IS NOT medically necessary.