

Case Number:	CM15-0117056		
Date Assigned:	06/25/2015	Date of Injury:	06/01/2012
Decision Date:	08/25/2015	UR Denial Date:	06/02/2015
Priority:	Standard	Application Received:	06/17/2015

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: Massachusetts

Certification(s)/Specialty: Anesthesiology, Pain Management

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 41 year old female, who sustained an industrial injury on 06/01/2012. According to a consultation report dated 03/17/2015, the injured worker was seen for evaluation of her left shoulder. She had been having problems for about two years that she felt was related to repetitive stress at her job working on a production line. She had no treatment on the shoulder. She had taken Motrin. An MR arthrogram of the left shoulder performed on 08/09/2013 revealed evidence of tendinosis of the supraspinatus. Physical examination of the left shoulder demonstrated forward elevation to about 90 degrees, external rotation to 30 degrees and internal rotation to the buttock level. Acromioclavicular joint was tender. Greater tuberosity and proximal biceps were tender. Rotator cuff strength was 4/5 in the infraspinatus, supraspinatus and subscapularis all with tendon signs. Impingement test was positive. Plain radiographs of her left shoulder revealed mild arthritic changes of the greater tuberosity and subacromial space. Assessment was noted as left shoulder pain with possible adhesive capsulitis. The treatment plan included a cortisone injection and a course of physical therapy. The injured worker did not want to do the injection because she was feeling under the weather. Physical therapy would be two times a week for six weeks. She was to follow up in a week to do the injection, then in one month following the injection. If she did not respond to an injection, then consideration was going to be made for manipulation under anesthesia with arthroscopic lysis of adhesions with possible decompression and debridement and treatment of any rotator cuff or labral pathology in either arthroscopic or mini open fashion. On 03/30/2015, the injured worker underwent a cortisone injection to her left shoulder. The provider noted that she had not yet begun formal

physical therapy. According to a progress report dated 05/18/2015, the injured worker was still struggling with her left shoulder. She reported that the cortisone injection helped for about a week. Physical examination demonstrated forward elevation only to about 90 degrees, external rotation to about 20 degrees and internal rotation to the thigh. Acromioclavicular joint was tender. Greater tuberosity and proximal biceps were tender. The plan was to go forward with manipulation under anesthesia with arthroscopic lysis of adhesions, decompression and debridement and possible clavicle excision. If the inflammation was severe, the distal clavicle excision would not be done. The provider noted that prescriptions were given for a 30 day supply of anti-inflammatory medication, a limited supply of narcotic medication, a limited supply of antibiotics, antiemetic medication to reduce incidence of nausea, stool softener to reduce incidence of constipation and vitamin C to promote healing to be taken postoperatively. The provider also noted that physical therapy would be required after the procedure. Currently under review is the request for 60 tablets of Vitamin C 500mg, 80 tablets of Ibuprofen 600mg, 10 capsules of Colace 100mg and 50 tablets of Norco 7.5/325mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

60 tablets of Vitamin C 500mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Rxlist.com. Online. 2015.
<http://www.rxlist.com/ascorbic-acid-drug/indications-dosage.htm>.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment.

Decision rationale: The ACOEM Chapter 3 on Initial approaches to treatment indicates that specialized treatments or referrals require a rationale for their use. According to the documents available for review, there is no rationale provided to support the use of Vitamin C. Therefore, at this time, the requirements for treatment have not been met, and the request is not medically necessary.

80 tablets of Ibuprofen 600mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines non-steroidal anti-inflammatory drugs (NSAIDs) Page(s): 67-72.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 70-73.

Decision rationale: According to the MTUS 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. (Van Tulder-Cochrane, 2000) Recommended with cautions below. Disease-State Warnings for all NSAIDs: All NSAIDs have [U.S. Boxed Warning]: for associated risk of adverse cardiovascular events, including, MI, stroke, and new onset or

worsening of pre-existing hypertension. NSAIDs should never be used right before or after a heart surgery (CABG - coronary artery bypass graft). NSAIDs can cause ulcers and bleeding in the stomach and intestines at any time during treatment (FDA Medication Guide). See NSAIDs, GI Symptoms and Cardiovascular Risks. Other disease-related concerns (non-boxed warnings): Hepatic: Use with caution in injured workers with moderate hepatic impairment and not recommended for injured workers with severe hepatic impairment. Borderline elevations of one or more liver enzymes may occur in up to 15% of injured workers taking NSAIDs. Renal: Use of NSAIDs may compromise renal function. FDA Medication Guide is provided by FDA mandate on all prescriptions dispensed for NSAIDs. Routine Suggested Monitoring: Package inserts for NSAIDs recommend periodic lab monitoring of a CBC and chemistry profile (including liver and renal function tests). There has been a recommendation to measure liver transaminases within 4 to 8 weeks after starting therapy, but the interval of repeating lab tests after this treatment duration has not been established. Routine blood pressure monitoring is recommended. Overall Dosing Recommendation: It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual injured worker treatment goals. According to the documents available for review, it appears that the injured worker is taking this medication for long-term therapy of a chronic condition. Given the increased risks associated with long-term use of this medication and no documented evidence that the lowest possible dose is being used for the shortest period of time, the requirements for treatment have not been met and the request is not medically necessary.

10 capsules of Colace 100mg: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-97.

Decision rationale: According to the MTUS section on opioids, Colace is indicated for the prophylaxis of opioid induced constipation. The documentation indicates opioid induced constipation. Therefore, at this time, the requirements for treatment have been met and the request is medically necessary.

50 tablets of Norco 7.5/325mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 77-78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-97.

Decision rationale: According to the MTUS Chronic Pain Medical Treatment Guidelines section on Opioids, On-Going Management, p 74-97, (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and

documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the injured worker's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the injured worker's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain injured workers on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking 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. (Passik, 2000)

(d) Home: To aid in pain and functioning assessment, the injured worker should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management.

(e) Use of drug screening or injured worker treatment with issues of abuse, addiction, or poor pain control.

(f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion).

(g) Continuing review of overall situation with regard to non-opioid means of pain control.

(h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability.

Additionally, the MTUS states that continued use of opioids requires (a) the injured worker has returned to work, (b) the injured worker has improved functioning and pain. There is no current documentation of baseline pain, pain score with use of opioids, functional improvement on current regimen, side effects or review of potentially aberrant drug taking behaviors as outlined in the MTUS and as required for ongoing treatment. Therefore, at this time, the requirements for treatment have not been met and the request is not medically necessary.