

Case Number:	CM14-0147643		
Date Assigned:	09/23/2014	Date of Injury:	08/17/2012
Decision Date:	10/22/2014	UR Denial Date:	08/15/2014
Priority:	Standard	Application Received:	09/11/2014

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, has a subspecialty in Pain Management, and is licensed to practice in California. 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 patient is a 53-year-old female with date of injury of 08/17/2012. The listed diagnoses per [REDACTED], PA, are: 1. Chronic pain syndrome. 2. Right shoulder pain. 3. Myalgia. 4. Allodynia. 5. Rotator cuff syndrome. 6. RTC tear. 7. Labrum tear. 8. Adhesive capsulitis. 9. Depression. 10. Right shoulder arthroscopy from 05/17/2013 11. Status post right shoulder surgery from 05/23/2014, 12. Status post AC joint steroid injection from 10/24/2013. According to this report, the patient has completed therapy as instructed. The patient continues to have pain and weakness even though she is performing her home exercise program daily. She reports extreme pain on the top of her shoulder when touched. The patient states that she is having difficulty holding, grasping, and lifting things. The medications are helpful and well tolerated including Flexeril, ibuprofen, and Ambien. She describes her pain as constant aching with burning and numbness down her shoulder to her elbow. The patient rates her pain 7/10 without medications and 3/10 with medication. The exam shows the patient is well nourished, well developed, in no acute distress. Significant trigger point tenderness to palpation of the right upper trap to occiput region, mid to lower trapezius, and bicep insertion/anterior shoulder region was noted. Fair scapulohumeral rhythm with related myofascial restrictions and interscapular tightness appreciated. Strength on the right is 4+/5 within available range. Grip strength is 5-/5. The treater references an MRI from 01/29/2014 that show considerable defect of the supraspinatus tendon since prior study. In addition, there remain moderate extensive longitudinal intrasubstance tears and fraying and tendinopathy of the supraspinatus and to a lesser extent infraspinatus tendons. The utilization review denied the request on 08/15/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management, Opioids, long-term assessment Page(s): 78, 88.

Decision rationale: This patient presents with right shoulder pain. The patient is status post right shoulder surgery from 05/23/2014. The treater is requesting Norco 10/325 mg quantity #60. For chronic opiate use, the MTUS Guidelines page 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4 A's including analgesia, ADLs, adverse side effects, and aberrant drug-seeking behavior, as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medications to work, and duration of pain relief. The records show that the patient was prescribed Norco on 02/06/2014. However, prior medication history was not made available. The 07/31/2014 report notes that the patient's pain without medication is 7/10 and with medication is 3/10. The treater also states, "We feel these medications will help decrease will help decrease muscle spasms and myofascial restrictions that impair her overall range of motion, decrease pain and inflammation, and improve functional mobility. Opiates are necessary for chronic intractable pain." The patient has signed an opioid agreement and her CURES report was consistent with prescribed medications. She is currently on modified duty but it is not known whether or not the patient is working. In this case, while the treater feels that the patient needs to be on opiates, analgesia documented along with general statements regarding function, no specific ADL's or return to work is discussed to determine whether or not significant functional improvement has been achieved. There is no discussion of urine toxicology for aberrant behavior and outcome measures are not discussed as required by MTUS. Recommendation is for denial and slow taper.

Lidoderm 5% patch #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Lidocaine Page(s): 112.

Decision rationale: This patient presents with right shoulder pain. The treater is requesting Lidoderm 5% patch quantity #60. The MTUS Guidelines page 57 states, "Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy (tricyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica)." MTUS page 112 also states, "Lidocaine Indication: Neuropathic pain recommended for localized peripheral pain." When reading ODG Guidelines, it specifies that Lidoderm patches are

indicated as a trial if there is "evidence of localized pain that is consistent with a neuropathic etiology." ODG further requires documentation of the area for treatment, trial of a short-term use with outcome documented pain and function. The 02/06/2014 report shows that the patient is utilizing Terocin lotion. The 07/31/2014 report shows that the patient was prescribed Lidoderm patches to the right shoulder and upper back for topical and postsurgical scar pain relief. In this case, Lidoderm patches are indicated for neuropathic pain, which this patient does not present with. Lidoderm is not indicated for back or shoulder pains per MTUS. Recommendation is for denial.

Motrin 800mg #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain , Anti-inflammatory medications NSAIDs

Decision rationale: This patient presents with right shoulder pain. The treater is requesting Motrin 800 mg quantity #90. The MTUS Guidelines page 22 on antiinflammatory medications states that antiinflammatories are the traditional first line treatment to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. The MTUS Guidelines page 60 and 61 on medications for chronic pain states that it is recommended; however, the relief of pain with the use of medications is generally temporary, and measures of lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. The records show that the patient has been prescribed Motrin since 2012. The 07/31/2014 report notes, "We feel these medications will help decrease muscle spasms and myofascial restrictions that impair her overall range of motion, decrease pain and inflammation, and improve functional mobility." In this case, the treater documents some efficacy with Motrin. Given the support for this medication per MTUS, recommendation is for authorization.

Flexeril 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Musclerelaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available) Page(s): 64.

Decision rationale: This patient presents with right shoulder pain. The treater is requesting Flexeril 7.5 mg quantity #60. The MTUS Guidelines page 64 on cyclobenzaprine states that it is recommended as a short course of therapy with limited mixed evidence not allowing for chronic use. Cyclobenzaprine is a skeletal muscle relaxant and central nervous system depressant with similar effects to tricyclic antidepressants (amitriptyline). This medication is not recommended to be used for longer than 2 to 3 weeks. The records show that the patient was prescribed Flexeril

on 02/06/2014. MTUS does not recommended the long-term use of this medication. Recommendation is for denial.

Ambien 10mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ambien ODG guideline have the following regarding Ambien for insomnia: Zolpidem [Ambien® (generic available), Ambien CR] is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Ambien CR is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. Longer-term studies have found Ambien CR to be effective for up to 24 weeks in adults.

Decision rationale: This patient presents with right shoulder pain. The treater is requesting Ambien 10 mg quantity #30. The MTUS and ACOEM Guidelines are silent with regards to this request; however, ODG Guidelines on zolpidem states that it is indicated for short-term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. The records show that the patient was prescribed Ambien on 03/10/2014. In this case, ODG does not support the long-term use of Ambien for the treatment of insomnia. Recommendation is for denial.