

Vanguard MedReview, Inc.

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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Famotidine

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

This reviewer is a Board Certified Orthopaedic Surgeon with over 13 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who sustained an injury to the right shoulder on xx/xx/xx while employed. She sustained a separate injury on xx/xx/xx.

11/07/2012: Office Visit. **HPI:** Patient presents today in regard to her right shoulder. She suffered an injury of the right shoulder on xx/xx/xx. She had a reinjury xx/xx/xx. She has had continued pain in the shoulder with radiation to the upper arm area. The patient has had continued treatment with physical therapy. She has been taking Hydrocodone. She has had pain in her neck area and the shoulder with radiation to the upper arm. **Medications:** Hydrocodone **Physical Examination:** Alert and oriented x 3. Cranial services II through XII grossly intact. Motor exam was 5/5, DTR's were 2+ and symmetrical. Musculoskeletal: Examination reveals tenderness in the anterior acromial area. The patient has pain with palpation along the anterior aspect of the acromion. The patient has pain in the acromioclavicular joint. The patient has a positive anterior impingement sign with pain. There is crepitation in the subacromial bursa area. The patient has a positive Hawkins' test with pain. There is tenderness over the greater tuberosity to palpation. The deltoid is intact but tender to palpation. The patient has a range of

motion that demonstrates 60 degrees forward flexion with pain, abduction of 50 degrees with pain and external rotation of 20 degrees. The patient has internal rotation to the hip. The patient has a reduction of muscle strength by 50% in regard to forward flexion and abduction against resistance. This also creates pain. The patient has weakness in external rotation against resistance also. The patient has a biceps tendon that is tender to palpation and has a positive Speed's test. The patient has intact pulses in the distal forearm. Neurological examination of the forearm and hand are intact with good ROM. **Plan:** Imaging: The patient had an MRI of the right shoulder performed on October 3, 2012. This shows tendinosis of the supraspinatus and subscapularis tendons of the rotator cuff. There is down-sloping of the acromion with impingement in the area. **Assessment:** Right shoulder rotator cuff strain. Right shoulder anterior subacromial impingement with tendinosis of rotator cuff tendons. The patient is also having cervical spine pain. **Plan:** Today, I injected the right shoulder subacromial bursa with Marcaine and Depo Medrol. Verbal informed consent was obtained. The site was prepped with alcohol. Using sterile technique, the site was anesthetized with 2 cc of 1% Lidocaine. The joint was then injected with 4 cc of 0.25% Marcaine mixed with 1 cc of Depo-Medrol 40 mg. A band aid was applied to the puncture site. The patient tolerated the procedure without incident. The patient is going to continue physical therapy. She needs to see a physician regarding her spine problem. I will see her again in follow-up in four weeks.

11/09/2012: MRI of the Cervical Spine without contrast. **Impression:** 1. Tiny central disc protrusion at C4-C5 and C6-C7 levels without impingement on spinal cord or nerve root. 2. No evidence of spinal stenosis. 3. Normal spinal cord.

10/02/2012: MRI of the right shoulder without contrast. **Impression:** 1. Supraspinatus and subscapularis tendinosis. 2. Mild changes of osteoarthritis in the gleno-humeral joint. 3. Minimal synovial effusion. 4. Minimal thickening of inferior gleno-humeral ligament. 5. Minimal thickening of inferior gleno-humeral ligament. 6. Mild degenerative changes in the acromio-clavicular joint. 7. Mild lateral down sloping of the acromion. 8. Minimal fluid in subacromial-subdeltoid and subcoracoid bursae.

05/16/2013: History and Physical. **Subjective:** Patient injured herself while at work. She states she was pulling when she felt pain in her neck. This extends across the shoulder. Initially, she was seeing. She was placed on tramadol. She is using about 14 to 16 of these per day. She was then referred to for pain management and evaluation. She was placed on hydrocodone 10 mg and then decreased to 7.5 mg because of sedation. She was placed on Naprelan. They recommended neck injections. She states she does not wish any interventional treatment at this point in time. She was placed on meloxicam. She states she was placed in PT and that it caused increase in neck pain. She saw for evaluation. She underwent shoulder injection which helped modestly. **Physical Examination:** Grip strength is decreased on the right side. ROM of the cervical spine is limited with rotation to the right side. There is some numbness over the distal tips of the fingers. There is tenderness over the right glenohumeral joint, worse with abduction and external rotation. **Assessment:** 1. Cervical Radiculitis, right upper

extremity 2. Intractable right shoulder pain 3. Cervicalgia **Plan:** I will maintain this patient on hydrocodone. I would like to add meloxicam twice daily. We will see if this would help pain and functional status. At this point in time, I believe we need to obtain EMG nerve conduction studies of the right upper extremity as a diagnostic endeavor to see if we can bring things to conclusion for this patient.

07/25/2013: Office Visit. **Subjective:** Patient complains of neck pain with radiation across the shoulder. This radiates into the upper right extremity. **Physical Examination:** There is tenderness over the cervical paraspinal segments. This extends across the right suprascapular area. This extends to the right shoulder. Right shoulder is limited in abduction. There is tenderness over the right upper extremity. Grip strength is somewhat decreased. **Assessment:** 1. Cervical Radiculitis, right upper extremity. 2. Chronic intractable right shoulder pain. 3. Cervicalgia. **Plan:** I will continue this patient on her Neurontin. I will increase her Neurontin to 100 mg twice daily and 200 mg at bedtime. We will see if we can make some headway in regard to her EMG nerve conduction study. My hope is this will be done as a diagnostic endeavor to determine what options this patient has.

03/18/2014: Operative Report. **Post-Operative Diagnoses:** Impingement syndrome, labral tear, adhesions and partial rotator cuff tear. **Operation:** Right shoulder arthroscopy with subacromial decompression and acromioplasty, debridement of labral tear, removal of adhesions, and micro-tenotomy rotator cuff.

08/20/2014: Office Visit. **HPI:** Completed only 12 sessions of PT due to CTR. Still lacks motion and strength. **Examination:** Right shoulder: ROM: active forward elevation less than passive @ 0-100. Strength testing (out of 5): 3/5 all RTC groups. Palpation: tenderness over proximal humerus, tenderness subacromial space, tender over the bicipital groove. Neck Exam: tenderness over trapezium muscle, tenderness over paracervical muscles. **Assessment:** 1. Sprain of shoulder 2. Rotator cuff syndrome 3. Strain of supraspinatus muscle or tendon 4. Strain of subscapularis muscle. **Plan:** Patient states she had significant delay of post-op PT of shoulder due to right hand/wrist surgery 6/27/14. Emphasized importance of post therapy. The patient needs more PT to regain optimal ROM and strength in order to maximize surgical outcome goals. Recommending physical therapy 3x/week x 6-8 weeks. Recommend TENS unit. Follow up 2 months.

10/06/2014: Office Visit. **HPI:** Continues with pain of right shoulder that radiates down arm to elbow. **Objective:** right shoulder ROM: active forward elevation significantly improved but still lacks strength. Strength testing: 4/5 all TRC groups. Palpation: Tenderness over proximal humerus. Neck Exam: tenderness over trapezium muscle, tenderness over paracervical muscles, tenderness over spinous process, decreased/restricted cervical ROM. Upper extremity exam: decreased sensation to light touch distally, decreased sensation over lat. Deltoid. **Assessment:** 1. Sprain of shoulder 2. Rotator cuff syndrome 3. Strain of supraspinatus muscle or tendon 4. Strain of subscapularis muscle. **Plan:** Patient is pleased with surgical outcome of right shoulder but continues with cervical

radicular symptoms. She has completed post op PT for shoulder and will continue home exercises that doesn't aggravate cervical condition. Patient is released for right shoulder care. RTC prn.

10/16/2014: Office Visit. **HPI:** is seen in follow up. She has had no improvement in her symptomatology which she describes as right sided neck pain with radiation into the right shoulder along the lateral arm to the elbow with associated numbness and tingling in a similar distribution. She also describes severe headache. Pain level is currently 8/10 on visual analog scale with worsening symptomatology following prolonged sitting, standing, coughing, sneezing and Valsalva maneuver. **Examination:** Cervical ROM was restricted in lateral rotation secondary to pain. Motor exam reveals 4/5 strength of the deltoid muscle on the right and there is 4+/5 strength of the biceps brachii and wrist extensor muscles on the right, otherwise 5/5 throughout. Deep tendon reflexes were +2 throughout and symmetrical. Plantar responses were flexor bilaterally. Straight leg raise was negative. Spurling's sign was positive on the right. Sensory exam reveals a hypoesthetic region over the C5 and C6 distributions on the right to pin prick and light touch, otherwise intact. **Impression:** 1. Cervical Radiculitis 2. Cervicalgia **Recommendations:** 1. Obtain an EMG/NCV of bilateral upper extremities. Follow up after completion.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The previous adverse determinations are upheld. The patient does not require famotidine at the present time. Famotidine (Pepcid) inhibits the production of acid in the stomach. It is frequently prescribed in conjunction with non-steroidal anti-inflammatory medications, which can erode the lining of the stomach in some patients. Famotidine is indicated in patients who have a history of peptic ulcer disease or have documented gastric intolerance to certain medications. Patients are not routinely placed on famotidine for prophylaxis. There is no indication in the records reviewed that this patient has had any issues tolerating the medications. There is no mention of previous peptic ulcer disease. Famotidine is not recommended for this patient.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- INTERQUAL CRITERIA**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**