

<b>Case Number:</b>	CM13-0034767		
<b>Date Assigned:</b>	03/19/2014	<b>Date of Injury:</b>	11/13/2012
<b>Decision Date:</b>	04/23/2014	<b>UR Denial Date:</b>	10/10/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/15/2013

### 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 & Rehabilitation, has a subspecialty in Interventional Spine 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 16-year-old female with a date of injury of 11/13/2012. The listed diagnoses per [REDACTED] are: 1) Rotator cuff syndrome, 2) Glenoid labral tear. According to report dated 10/01/2013 by [REDACTED], the patient complains of right shoulder, upper back, right arm pain. The pain is noted as 6/10. Patient continues to report continued pain and reduced strength in the right upper extremity. There is muscle spasms of right shoulder, right arm, and upper back. Patient states that Norco is helpful for reducing pain but not strong enough. Examination revealed the right shoulder showed guarded range of motion with decreased painful ROM at 25 degrees. Treater requested authorization for a trial of Zanaflex 4 mg #25 and continued use of Tylenol ES 500 mg, trazodone 50 mg #90, and Norco 5/325 mg #90. Progress report dated 08/14/2013 by [REDACTED], reports patient complains of right shoulder pain that radiates down to the right biceps, wrist, and hand with associated numbness in the right biceps. The patient describes pain at 5/10 on a constant basis on the visual analog pain scale. Past medical history includes medications tramadol and Trazodone and two lumbar spine surgeries in 1988 and 1989.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TRIAL OF ZANAFLEX 4MG #25:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ZANAFLEX.

**Decision rationale:** The Expert Reviewer's decision rationale: This patient presents with continued shoulder, upper back and right arm pain. The treater is requesting a trial of Zanaflex 4 mg #25. Utilization review dated 10/10/2013 denied the request stating, there is "absence of acute myospasm or pain". The MTUS Guidelines page 66 allows for the use of Zanaflex for low back pain, myofascial pain, and fibromyalgia. In this case, as documented in report date 10/01/2013, the patient reports continued pain and muscle spasms of the right shoulder, right arm, and upper back. At this time, a trial of Zanaflex may be warranted. Recommendation is for approval.

**PRESCRIPTION OF TYLENOL ES 500MG #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS CHRONIC PAIN GUIDELINES.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ACETAMINOPHEN (APAP).

**Decision rationale:** The Expert Reviewer's decision rationale: This patient presents with continued complaints of right shoulder, upper back, and right arm pain. Treater is requesting Tylenol ES 500 mg #120. The MTUS guidelines recommends Acetaminophen as a first line of treatment for chronic pain and acute exacerbation of chronic pain. In this case, medical records indicate the patient has been taking Tylenol since 06/25/2013. There are 2 progress reports provided for review dated 08/14/2013 and 10/01/2013. Neither of these reports provides any discussions regarding whether or not Tylenol has provided any specific functional improvements. Although the treater has stated that current pain is 6/10, there is no other pain assessment to denote function, etc. MTUS page 60 requires documentation of pain assessment and functional changes when medications are used for chronic pain. Another concern is that the patient is being prescribed Norco which contains 325mg per pill. The total amount of tylenol appears to 3975mg per day which exceeds what is recommended for a daily limit of 3600mg. It does not appear that the treater is aware of how much tylenol this patient is taking. Recommendation is for denial.

**TRAZODONE 50MG #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS CHRONIC PAIN GUIDELINES, ANTIDEPRESSANTS FOR CHRONIC PAIN.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Citation: OFFICIAL DISABILITY GUIDELINES (ODG) REGARDING REMERON FOR INSOMNIA

**Decision rationale:** The Expert Reviewer's decision rationale: This patient presents with continued complaints of right shoulder, upper back, and right arm pain. The treater is requesting trazodone 50 mg #90. Utilization review dated 10/10/2013 modified certification to 1 month. Trazodone is classified as an antidepressant. The MTUS Guidelines do not address this medication for insomnia, but ODG Guidelines support it when there is a concurrent depression diagnosis. There are 2 reports provided for review dated 10/01/2013 and 08/14/2013. Neither of these reports provides any discussions on whether this patient has a diagnosis of depression or insomnia. This medication is not indicated at this time. Recommendation is for denial.

**NORCO 5/325MG #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS CHRONIC PAIN GUIDELINES.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, MEDICATIONS FOR CHRONIC PAIN Page(s): 60-61.

**Decision rationale:** The Expert Reviewer's decision rationale: This patient presents with continued right shoulder, upper back, right arm pain. The treater is requesting a refill of Norco 5/325 mg #90. For chronic opiate use, MTUS Guidelines page 88 and 89 require functioning documentation using a numerical scale or validated instrument at least once every 6 months. Documentation of the 4As, analgesia, ADLs, adverse side effects, adverse behavior, is required. Furthermore, under outcome measures, it also recommends documentation of current pain, average pain, least pain, time it takes for medication to work, duration of pain relief with medication, etc. There are 2 progress reports provided for review dated 10/01/2013 and 08/14/2013. Neither of these reports provides any discussions on functional improvements with Norco. The patient does state, "Norco is helpful for reducing pain but not strong enough." MTUS requires documentation of the 4As and under outcome measures, documentation of current average and least pain, etc. In this case, none of these are discussed. Given the lack of sufficient documentation warranting long-term opiate use, recommendation is for denial.