

Case Number:	CM13-0070088		
Date Assigned:	01/03/2014	Date of Injury:	10/14/2002
Decision Date:	05/28/2014	UR Denial Date:	12/06/2013
Priority:	Standard	Application Received:	12/24/2013

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 and is licensed to practice in Texas. 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 injured worker is a 54 year old male who reported an injury on 10/14/2002 secondary to unknown mechanism of injury. The diagnoses include left shoulder rotator cuff strain and chronic impingement with flap tear and AC joint degeneration and right shoulder rotator cuff syndrome with prior surgery. The injured worker was evaluated on 11/15/2013 for reports of bilateral shoulder and neck pain rated at 8/10. The exam no objective findings of pain levels, functional deficits, or monitoring for aberrant drug-related behaviors. The treatment plan indicated neurological evaluation, acupuncture, home exercise and continued medication plan. The injured worker reported the medications decrease pain by 75% with no side effects. There is a request for authorization in the documentation provided dated 11/26/2013; however, no rationale is noted.

IMR ISSUES, DECISIONS AND RATIONALES

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

NORCO 10/325 MG #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: The MTUS Chronic Pain Guidelines recommend the use of opioids for ongoing management of chronic pain. The Guidelines also state there should be ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The documentation provided shows no monitoring for aberrant drug taking behaviors. Therefore, based on the documentation provided, the request is not medically necessary and appropriate.

TRAZADONE 100MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG, Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13-16.

Decision rationale: The MTUS Chronic Pain Guidelines state the use of antidepressants is recommended as a first line option for neuropathic pain and possibly non-neuropathic pain with assessment of treatment efficacy including not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. There is no evidence of objective assessment of efficacy of the medication, sleep quality, functional changes or psychological assessment. Based on the documentation provided, the request is not medically necessary and appropriate.

NEURONTINE 800MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-17.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTIPILEPSY DRUGS Page(s): 16-18.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines recommend the use of Neurontin for treatment of neuropathic pain. There is no evidence in the medical records provided for review of an objective assessment of efficacy of the medication. Therefore, based on the documentation provided, the request is not medically necessary and appropriate.

AMBIEN 10MG #27: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: The Official Disability Guidelines (ODG) state that zolpidem is approved for short-acting treatment of insomnia. The injured worker has been prescribed Ambien since at

least 05/13/2013. This exceeds the time for short-term use. Therefore, based on the documentation provided, the request is not medically necessary and appropriate.

ZANAFLEX 6MG #27: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

Decision rationale: The MTUS Chronic Pain Guidelines state the use of Zanaflex is approved for the management of spasticity and unlabeled use for the management of low back pain. There is no evidence in the documentation provided of the injured worker reporting or objective evidence of muscle spasm or low back pain. Furthermore, the injured worker has been taking the medication for greater than 4 weeks as recommended by the MTUS Chronic Pain Guidelines. Therefore, based on the evidence provided, the request is not medically necessary and appropriate.

CYMBALTA 30MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 15-16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTIDEPRESSANTS Page(s): 16.

Decision rationale: The MTUS Chronic Pain Guidelines state the use of Cymbalta for depression, anxiety, diabetic neuropathy and fibromyalgia is recommended with off-label use for neuropathic pain and radiculopathy. There is no evidence of depression, anxiety, diabetic neuropathy, fibromyalgia, neuropathic pain or radiculopathy in the documentation provided. Therefore, based on the documentation provided, the request is not medically necessary and appropriate.