

<b>Case Number:</b>	CM13-0071473		
<b>Date Assigned:</b>	01/08/2014	<b>Date of Injury:</b>	07/01/2011
<b>Decision Date:</b>	06/24/2014	<b>UR Denial Date:</b>	12/19/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/27/2013

### 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 Internal Medicine 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:

This is a 62-year-old male with a 7/1/11 date of injury. He is noted to be status post total shoulder arthroplasty in 2006 and status post arthroscopy of the right shoulder on 4/29/13 for loose glenoid removal and autologous tissue graft. He had a right shoulder revision TKA on 9/7/13. The provider saw him on 12/3/13 where it was noted the patient was doing well in physical therapy for his right shoulder and subsequently pulled it and lost range of motion and strength. He complained of increased pain and was not able to move his shoulder well. Exam findings revealed limited range of motion of the right shoulder with marked weakness. His symptoms were consistent with frozen shoulder. He was noted to be on 5 Norco per day, 1-2 Trazodones per night, and Zanaflex twice daily. On 12/11/13 a possible infection of the right shoulder was noted with swelling in the arm with activity. Bleeding in the biceps was noted and he was not able to move the shoulder or arm. Aber test was positive with very limited range of motion. Plain films noted impaction of the glenoid into the bone and that the joint was no longer moving properly. UR decision dated 12/3/13 modified the request for Norco 10/325 from 900 to 100 given the documentaiton did not provide evidence of functional improveemnt and no pain contract was documented. The request was modified to allow for a taper or additional clinical information. The request for Trazodone was modified from 360 to 60, and Zanaflex from 360 to 60 to initiate a taper.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**NORCO 10/325MG #900:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 78-81.

**Decision rationale:** The CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The patient was noted to be on 5 Norco per day as of 12/11/13 given he had glenoid impaction into the bone of the right shoulder and was not able to move his arm. The UR decision was to taper the patient from 900 to 100. The patient was on a total of 150 Norco per month; hence the request for 900 Norco was not medically necessary.

**TRAZADONE 50MG #360:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Antidepressants For Chr.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Pain Chapter Trazodone

**Decision rationale:** The CA MTUS does not address this issue. ODG recommends Trazodone as an option for insomnia only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. Trazodone has also been used successfully in fibromyalgia. The patient was noted to be on 1-2 Trazodones per night for sleep as of 12/11/13, which would be 30-60 tablets per month. The UR decision was to modify the request for 360 tablets to 60 tablets, which would be an appropriate amount per the documentation that the patient was taking. Thus, the request for 360 Trazodone tablets was not medically necessary.

**ZANAFLEX 4MG #360:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Antispasticity/Antispas.

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

**Decision rationale:** The CA MTUS Chronic Pain Medical Treatment Guidelines recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP, however, in most LBP cases; they show no benefit beyond NSAIDs in pain and overall improvement. The patient was noted to be on Zanaflex twice daily as of 12/11/13, which would be 60 tablets per month. The UR decision

modified the request from 360 tablets to 60 tablets, which is an appropriate amount given the documentation. Thus, the request for 360 Zanaflex was not medically necessary.