MAXIMUS Federal Services

| Case Number: | CM14-0151798 | | |
|---|---|---|---|
| Date Assigned: | 09/22/2014 | Date of Injury: | 10/20/2008 |
| Decision Date: | 10/21/2014 | UR Denial Date: | 09/15/2014 |
| Priority: | Standard | Application Received: | 09/17/2014 |

## 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 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:

Medical records reflect the claimant is a 47 year old male who sustained a work injury on 10-20-08. The claimant has a diagnosis of traumatic shoulder arthropathy. The claimant has been treated with medications, activity modification, home exercise program and surgery (3-7-12: right shoulder retro coracoid decompression with extensive superior labral tear debridement).Office visit on 8-4-14 noes the claimant has bilateral knee and anterior shoulder pain. On exam, the claimant has 90 degrees abduction. There was tenderness at AC joint, and bicipital groove. The claimant has positive belly press and Obrien's test for both shoulders. The claimant has negative drawer test, Lachman's and pivot shift test for both knees. The claimant has intact sensation.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Zoloft 25mg, #30:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines anit depressants Page(s): 13-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter â¿¿ anti depressants

**Decision rationale:** Chronic Pain Medical Treatment Guidelines as well as ODG reflect that anti-depressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. This claimant has chronic neck and shoulder complaints. He is status post right shoulder surgery with residual pain. Therefore, the medical necessity of this request is established as reasonable and indicated.

**Sonata #30:**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- Chapter: Pain Insomnia treatment

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter â¿¿ insomnia treatment

**Decision rationale:** ODG notes that Zaleplon (Sonata) reduces sleep latency. Side effects: headache, drowsiness, dizziness, fatigue, confusion, abnormal thinking. Sleep-related activities have also been noted such as driving, cooking, eating and making phone calls. Abrupt discontinuation may lead to withdrawal. Dosing: 10 mg at bedtime (5 mg in the elderly and patients with hepatic dysfunction). (Morin, 2007) Because of its short half-life (one hour), may be readministered upon nocturnal wakening provided it is administered at least 4 hours before wake time. (Ramakrishnan, 2007) This medication has a rapid onset of action. Short-term use (7-10 days) is indicated with a controlled trial showing effectiveness for up to 5 weeks. This claimant sleep hygiene is not discussed, past treatment tried and failed. Additionally, the long term use of this medication is not indicated. Therefore, the medical necessity of this request is not established.

**Ibuprofen 600mg, #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-73. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter - NSAIDS

**Decision rationale:** Chronic Pain Medical Treatment Guidelines as well as ODG reflect that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. There is an absence in documentation documenting medical necessity for the long term use of an NSAID. There is no documentation of functional improvement with this medication. Therefore, the medical necessity of this request is not established.