

Case Number:	CM14-0027838		
Date Assigned:	06/16/2014	Date of Injury:	02/17/2010
Decision Date:	07/31/2014	UR Denial Date:	02/12/2014
Priority:	Standard	Application Received:	03/05/2014

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 Internal Medicine, Pulmonary Diseases 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 injured worker is a 41-year-old male who reported a circular torquing injury to his left shoulder on 02/17/2010. On 07/07/2010, he underwent a left shoulder MRI which revealed a partial thickness tear of the rotator cuff measuring approximately 6 to 7 mm in diameter. In an orthopedic examination of 11/23/2010, he complained of experiencing constant sharp stabbing pain in his left shoulder. The pain radiated down his arm into his hand and fingers and up into his neck. His shoulder pain was increased with lifting, carrying, pushing, pulling, and reaching at and above shoulder level. He experienced stiffness, tightness, grating, popping, crackling, and clicking in his shoulder. He experienced weakness, numbness and tingling in his arm, hands, and fingers. He stated that the pain awakens him from sleep at night on a daily basis. At that time, he rated his pain at 6/10 to 7/10. At its worst, it was 9/10 and at its best it was 5/10. At that time, he was not taking any medications. The range of motion in his left shoulder measured in degrees was flexion 150/180, extension 30/50, abduction 140/80, adduction 30/50, external rotation 80/90, and internal rotation 60/90. His diagnoses at that time included chronic pain syndrome secondary to herniated cervical disc with radiculitis; left shoulder tenderness, impingement/tear; anxiety and depression; and insomnia. The medications recommended for him at that time were Norco for pain, Zanaflex as a muscle relaxant, Anaprox for inflammation, Remeron for anxiety and depression, and Prilosec for upset stomach, as well as ketoprofen and capsaicin topical compounds. No dosages were given. He underwent arthroscopic surgery to his left shoulder in 2011, which did not provide any significant relief. On 01/23/2014, he underwent a revision arthroscopic surgery of the left shoulder with arthroscopic synovectomy of the glenohumeral joint and arthroscopic extensive debridement of the type 1 SLAP tear with inflammatory tissue overlying the rotator cuff tendon. His postoperative diagnoses included impingement syndrome with bursitis and extensive adhesions of the subacromial space, acromioclavicular joint

osteoarthritis with osteophytes and adhesions around the distal clavicle left shoulder, adhesive capsulitis, synovitis of the glenohumeral joint, adhesions of synovial tissue of the glenohumeral joint, type I SLAP tear, adhesions and inflammatory tissues overlying the rotator cuff, and restricted and painful range of motion. During the postoperative followup examination on 01/28/2014, he complained of worsening pain accompanied with headaches and neck and low back pain. He rated his left shoulder pain at 9/10. He further reported he was having numbness in his left hand with pain radiating to his arm. Prior to the surgery in 01/2014 his therapies had included rest, ice, NSAIDs, steroid injections, physical therapy, and extracorporeal shockwave therapy. In the pain management consultation on 02/25/2014, it is noted that he was going to start postoperative physical therapy. No schedule of physical therapy was documented. His range of motion to the left shoulder at that time measured in degrees was flexion 80/180, extension 40/50, abduction 80/180, adduction 40/50, internal rotation 90/90, and external rotation 90/90. At that time, his pain medications included Norco 10/325 mg, Anaprox DS 550 mg, Fexmid 7.5 mg, and Prilosec 20 mg. On 09/23/2013, he had a left shoulder MR arthrogram which showed a tear involving the superior labrum and tiny perforation to the infraspinatus tendon. There was no request for authorization within the submitted material and no rationale for the Fexmid 7.5 mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

REMERON 15MG, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TRICYCLIC ANTIDEPRESSANTS Page(s): 13-14.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness & Stress, Antidepressants.

Decision rationale: The request for Remeron 15 mg, #60 is non-certified. The American College of Occupational and Environmental Medicine, Second Edition, General Approach and Basic Principles of Stress related Conditions recommends that medications generally have a limited role. Limited use of anti-anxiety agents for short periods of time, that is periods when overwhelming anxiety limits the patient's ability to work or effectively perform activities of daily living. Antidepressant or antipsychotic medications may be prescribed for major depression or psychosis; however, this is best done in conjunction with specialty referral. The ODG recommends antidepressants, although not generally as a standalone treatment. Antidepressants have been found to be useful in treating depression, including depression in physically ill patients. It further states that antidepressants offer significant benefit in the treatment of the severest depressive symptoms, but may have little or no therapeutic benefit over and above placebo in patients with mild to moderate depression. This study raises the question of whether patients with mild to moderate depression should have antidepressant therapy as a first line approach. There is an increased risk of depression in people with a physical illness, and depression is associated with reduced treatment adherence, poor prognosis, increased disability, and higher mortality in many physical illnesses. A new review of 4 meta-analyses of efficacy

trials submitted to the FDA suggests that antidepressants are only marginally efficacious compared with placebo and documented profound publication bias that inflates their apparent efficacy. In addition, when the researchers also analyzed the sequential treatment alternatives through relieve depression (STAR*D) trial, the largest antidepressant effectiveness trial ever conducted, they found that the effectiveness of antidepressant therapies was probably even lower than the modest 1 reported. In looking at sustained benefit, it was only 2.7%. It concluded that the findings argue for a reappraisal of the current recommended standard of care for depression. Although this record does have a diagnosis of depression and anxiety, there has been no documentation of a consultation with a psychologist or psychiatrist, and no diagnosis of major depressive disorder. On 08/03/2011, it was noted that he scored 17 out of a possible 61 points on the Hamilton Depression Rating Scale indicating a possible depressive disorder. On the Hamilton Anxiety Rating Scale, he obtained a score of 14 out of a possible 56 points, indicating slight symptomatology suggestive of a possible anxiety disorder. Additionally, the request did not include any frequency of administration. Therefore, this request for Remeron 15 mg, #60 is not medically necessary.

FEXMID 7.5MG, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, MUSCLE RELAXANTS (FOR PAIN) Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain), pages 63-64 Page(s): 63-64.

Decision rationale: The request for Fexmid 7.5 mg, #60 is not medically necessary. California MTUS Guidelines recommend nonsedating muscle relaxants with a caution as a second line option for short term treatment of acute exacerbations in patients with chronic low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most low back pain cases, they show no benefit besides NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Specifically mentioning cyclobenzaprine or Fexmid, it is recommended for a short course of therapy. Limited, mixed evidence does not allow for a recommendation for chronic use. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system depressant with similar effects to tricyclic antidepressants. There are no recommendations for its use in postoperative pain. Since it is a central nervous system depressant and the worker has a diagnosis of depression, Fexmid would be contraindicated. Additionally, there is no frequency included in the request. Therefore, this request for Flexmid 7.5 mg, #60 is not medically necessary.