

Case Number:	CM14-0078186		
Date Assigned:	07/18/2014	Date of Injury:	01/01/2001
Decision Date:	09/17/2014	UR Denial Date:	04/22/2014
Priority:	Standard	Application Received:	05/28/2014

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 Occupational 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:

Injured worker is a male with date of injury 1/1/2001. Per pain medicine progress note dated 3/28/2014, the injured worker reports a lot of pain and discomfort involving neck and right shoulder. The pain intensifies with physical activities. On examination there is decreased right shoulder range of motion as well as strength. There is a positive rotator cuff impingement test in the right shoulder. There is a positive Tinel's and Phalen's test in the wrist and hand. There is a well-healed surgical scar in the right shoulder and neck. There is also decrease in the cervical range of motion. Diagnoses include 1) left shoulder rotator cuff injury 2) left carpal tunnel syndrome 3) history of left shoulder release surgery on 8/27/2008 4) status post left shoulder capsular release surgery on 4/22/2009 5) status post cervical fusion C5 through C7 in November 2009 6) right shoulder internal derangement 7) right shoulder rotator cuff injury 8) cervical disc injury 9) right cervical radiculopathy 10) status post right shoulder surgery on 2/15/2011 11) status post right shoulder herniarthroplasty.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen cream.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines: Ketoprofen Topical Compound.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Approach to Chronic Pain Management section, Topical Analgesics section Page(s): 7,8,111,112.

Decision rationale: The injured worker reports that he liked Ketoprofen cream as it helped to control his pain and discomfort, although on a temporary basis. The MTUS Guidelines explain that the treatment of pain requires a thorough understanding of the mechanism underlying the pain as well as to identify comorbidities that might predict an adverse outcome. Consideration of comorbid conditions, side effects, cost, and efficacy of medication versus physical methods and provider and patient preferences should guide the physician's choice of recommendations. Choice of pharmacotherapy must be based on the type of pain to be treated and there may be more than one pain mechanism involved. The physician should tailor medications and dosages to the individual taking into consideration patient-specific variables such as comorbidities, other medications, and allergies. The physician should be knowledgeable regarding prescribing information and adjust the dosing to the individual patient. If the physician prescribes a medication for an indication not in the approved FDA labeling, he or she has the responsibility to be well informed about the medication and that its use is scientific and evidence-based. When effective, medications provide a degree of analgesia that permits the patients to engage in rehabilitation, improvement of activities of daily living, or return to work. Ketoprofen cream is a topical NSAID medication. The MTUS Guidelines report that topical Ketoprofen is not FDA approved, and is therefore not recommended by these guidelines. The request for Ketoprofen cream is determined to not be medically necessary.

Trazodone: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Guidelines Page(s): 7.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Approach to Chronic Pain Management section Page(s): 7. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain chapter, Insomnia Treatment section.

Decision rationale: The MTUS Guidelines explain that the treatment of pain requires a thorough understanding of the mechanism underlying the pain as well as to identify comorbidities that might predict an adverse outcome. Consideration of comorbid conditions, side effects, cost, and efficacy of medication versus physical methods and provider and patient preferences should guide the physician's choice of recommendations. Choice of pharmacotherapy must be based on the type of pain to be treated and there may be more than one pain mechanism involved. The physician should tailor medications and dosages to the individual taking into consideration patient-specific variables such as comorbidities, other medications, and allergies. The physician should be knowledgeable regarding prescribing information and adjust the dosing to the individual patient. If the physician prescribes a medication for an indication not in the approved FDA labeling, he or she has the responsibility to be well informed about the medication and that its use is scientific and evidence-based. When effective, medications provide a degree of analgesia that permits the patients to engage in rehabilitation, improvement of activities of daily

living, or return to work. The MTUS Guidelines do not address the use of Trazodone. The ODG reports that Trazodone is a sedating antidepressant and one of the most commonly prescribed agents for insomnia. Improvements in sleep onset with use of Trazodone may be offset by negative next day effects such as ease of awakening. Tolerance to Trazodone may develop and rebound insomnia has been found after discontinuation. The prescribing physician does not address the use of Trazodone with dose and number being prescribed. Medical necessity is not established by addressing benefits versus risks with this medication. The request for Trazodone is determined to be medically necessary.