MAXIMUS Federal Services

Case Number:	CM15-0138399		
Date Assigned:	07/28/2015	Date of Injury:	11/30/2010
Decision Date:	08/31/2015	UR Denial Date:	07/02/2015
Priority:	Standard	Application Received:	07/16/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Texas, California
Certification(s)/Specialty: Family Practice

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 55 year old female patient who sustained an industrial injury on 11/30/2010. She sustained the injury when she was lifting a milk crate and heard and felt a pop and felt pain immediately. Diagnoses include rotator cuff syndrome, status post right shoulder SLAP repair in 2010 and 2011, and left shoulder pain (industrially disputed). Per the doctor's note dated 7/8/2015, she had complaints of right shoulder pain. Per the physician progress note dated 06/10/2015 she has significant pain in her left shoulder that has gradually become worse as he has had to compensate and use that side more. She has continued to do well on her medications. She states her pain level today as 8 out of 10. It get as high as a 10 out of 10, coming down to a 6 out of 10 with the use of Tramadol. The physical examination revealed significantly reduced range of motion of the left shoulder, able to elevate to about 90 degrees, external rotation about 30 degrees. Current medications include Wellbutrin SR, Trazadone, Zanaflex, and Tramadol. She has had multiple surgeries on her right shoulder. Per the note dated 5/18/2015, patient had depression/anxiety secondary due to chronic pain. She has had an unofficial Magnetic Resonance Imaging of the right shoulder dated 10/17/2014 which revealed interstitial tear of the rotator cuff supraspinatus as well as moderate tendinosis and acromioclavicular joint arthrosis. She has had unspecified numbers of physical therapy for the right shoulder injury. The treatment plan includes a month's supply of Ultracet, Zanaflex and Trazadone, and she is supposed to be going in for some physical therapy for her right shoulder and physical therapy for her left shoulder is also requested. Treatment requested is for Retrospective review of Pharmacy

purchase of Wellbutrin 150mg #90, DOS: 06/10/15, and Retrospective review of Physical Therapy, eight (8) visits, DOS: 06/10/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective review of Physical Therapy, eight (8) visits, DOS: 06/10/2015: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical therapy Page(s): 98.

Decision rationale: Retrospective review of Physical Therapy, eight (8) visits, DOS: 06/10/2015: The cited guidelines recommend up to 9-10 physical therapy visits for this diagnosis. Per the records provided, patient has had unspecified numbers of physical therapy visits for this injury. There is no evidence of significant progressive functional improvement from the previous physical therapy visits that is documented in the records provided. Per the cited guidelines, "Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." A valid rationale as to why remaining rehabilitation cannot be accomplished in the context of an independent exercise program is not specified in the records provided. The medical necessity of retrospective review of Physical Therapy, eight (8) visits, DOS: 06/10/2015 is not established for this patient at this time.

Retrospective review of Pharmacy purchase of Wellbutrin 150mg #90, DOS: 06/10/15: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines Antidepressants for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Antidepressants for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Bupropion (Wellbutrin), page 16.

Decision rationale: Retrospective review of Pharmacy purchase of Wellbutrin 150mg #90, DOS: 06/10/15: Wellbutrin contains bupropion, an anti depressant drug. According to CA MTUS guidelines cited below "Bupropion (Wellbutrin), a second-generation non-tricyclic antidepressant (a noradrenaline and dopamine reuptake inhibitor) has been shown to be effective in relieving neuropathic pain of different etiologies in a small trial (41 patients). While bupropion has shown some efficacy in neuropathic pain there is no evidence of efficacy in patients with non neuropathic chronic low back pain." Per the records provided patient had chronic right and left shoulder pain with depression and anxiety. She has a history significant for multiple right shoulder surgeries. The request for Retrospective review of Pharmacy purchase of Wellbutrin 150mg #90, DOS: 06/10/15 is medically appropriate and necessary for this patient.