Case Number:	CM15-0166596		
Date Assigned:	09/04/2015	Date of Injury:	08/26/2014
Decision Date:	10/13/2015	UR Denial Date:	07/29/2015
Priority:	Standard	Application Received:	08/25/2015

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: New York
Certification(s)/Specialty: Anesthesiology

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 59 year old male, who sustained an industrial injury on 8-26-2014. The mechanism of injury is injury from repetitive shoveling. The current diagnoses are pain in joint involving shoulder region, rotator cuff tear, and SLAP tear, status post left shoulder arthroscopy (1-28-2015). According to the progress report dated 6-2-2015, the injured worker presents for follow-up of his shoulder. He reports that he is doing well and that he has returned to work. He states that his strength has improved. Currently he rates his pain 4 out of 10 on a subjective pain scale, which is decreased from 6 out of 10 on 1-20-2015. The physical examination of the shoulder reveals full range of motion. The RC power and biceps is intact. The shoulder is stable. The current medications are Norco and Ibuprofen. It is unclear when the Tramadol, Flexeril, Lunesta, and topical compound cream were originally prescribed, as they are not listed on his medication list. Treatment to date has included medication management, x-rays, heat, ice, physical therapy, MRI studies, and surgical intervention. Per the progress report on 5-27-2015, the injured worker was listed as permanent and stationary. On 6-2-2015, the documentation indicated that he had returned to work. A request for Tramadol, Flexeril, Lunesta, topical compound cream, and left shoulder steroid injection has been submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the California MTUS, Tramadol (Ultram) is a synthetic opioid, which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. According to the medical records, there has been no documentation of the medication's analgesic effectiveness or functional improvement, and no clear documentation that the patient has responded to ongoing opioid therapy. Prescriptions for opioids, per the MTUS, should be for the shortest term possible. In this case, there is a request for Tramadol without documentation of a specified quantity or duration. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic requires a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

Flexeril 7.5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: According to the reviewed literature, Amrix (Cyclobenzaprine) is a skeletal muscle relaxant and a central nervous system (CNS) depressant. It is closely related to the tricyclic antidepressants. It is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. Guidelines state that this medication is not recommended to be used for longer than 2-3 weeks. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested treatment is not medically necessary.

Lunesta (Eszopiclone) 3mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental Illness/pain chapters.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Eszopiclone (Lunesta).

Decision rationale: Eszopicolone (Lunesta) is a prescription short-acting non-benzodiazepine sedative-hypnotic, which is recommended for short-term treatment of insomnia (two to six weeks). Benzodiazepine-receptor agonists work by selectively binding to type-1 benzodiazepine receptors in the CNS. Lunesta is indicated for the treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. According to the ODG guidelines, non-Benzodiazepine sedative-hypnotics are considered first-line medications for insomnia. All of the benzodiazepine-receptor agonists are schedule IV controlled substances, which have potential for abuse and dependency. It appears that the non-benzodiazepines have similar efficacy to the benzodiazepines with fewer side effects and short duration of action. Eszopicolone has demonstrated reduced sleep latency, sleep maintenance, and is recommended for short-term use. In this case, there is no documentation that the patient had a history of insomnia or sleep disturbances. Medical necessity of the requested item has not been established. The requested medication is not medically necessary.

Topical compound cream: Gabapentin/ Amitriptyline cream to applied to the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: According to the CA MTUS Chronic Pain Medical Treatment Guidelines topical analgesics are recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. There is no topical preparation of Amitriptyline certified by the FDA. Gabapentin is not recommended, as there is no peer-reviewed literature to support its use. Medical necessity for the requested topical medication has not been established. The requested medication is not medically necessary.

Left shoulder Fluoroscopic guidance steroid injection AC joint (both regions): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Medical History.

Decision rationale: Per the CA MTUS ACOEM Medical Treatment Guidelines, invasive techniques have limited proven value. If pain with elevation significantly limits activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy (i.e., strengthening exercises and non-steroidal anti-inflammatory drugs) for two to three weeks. The evidence supporting such an approach is not overwhelming. The total number of injections should be limited to three per episode, allowing for assessment of benefit between injections. In this case, the guidelines specify that a corticosteroid injection may be given after conservative therapy if pain significantly limits activities. There is no documentation of activity limitations. The injured worker has returned to work, has full range of motion to the shoulder, and has minimal pain (4 out of 10). Therefore, based on ACOEM guidelines and submitted medical records, the request for fluoroscopic guidance steroid injection to the left shoulder is not medically necessary.