

Case Number:	CM15-0203651		
Date Assigned:	10/20/2015	Date of Injury:	09/11/2014
Decision Date:	12/22/2015	UR Denial Date:	09/23/2015
Priority:	Standard	Application Received:	10/16/2015

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: New York

Certification(s)/Specialty: Pediatrics, Internal Medicine

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 sustained an industrial injury on 9-11-2014. The injured worker was diagnosed as having disorders of bursae and tendons in shoulder region, unspecified, and rotator cuff syndrome. Treatment to date has included diagnostics, right shoulder surgery 2-02-2015, physical therapy, and medications. On 5-07-2015, the injured worker complains of right shoulder pain with radiation to the right arm, associated with weakness in the arm and rated 9-10 out of 10, 6 at best and 10 at worst. Functional limitations were noted as work avoidance, exercising, performing household chores, participating in recreation, driving, yard work, shopping, sexual relations, and caring for himself, due to pain. The use of Naproxen and Omeprazole was noted since at least 2-2015 (gastrointestinal irritation taking Naproxen without Omeprazole), Tramadol since at least 3-2015, and Trazadone since at least 5-07-2015. A visit report for 9-10-2015 was not noted within the submitted medical records. Per the next progress report dated 9-11-2015 (pain management), pain was reported as "severe and worse since the last visit", not numerically rated. Discussion notes documented "no change" and functional range of motion. Current function with activities of daily living or sleep hygiene was not described and work status was not documented.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Trazodone 50mg #60 (DOS 09/10/2015): Upheld

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

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

Decision rationale: Per ODG pharmacological agents for insomnia should only be used after careful evaluation of potential causes of sleep disturbance for the etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). First-line treatment is recommended to be non-benzodiazepine sedative-hypnotics such as Ambien, Ambien CR, Sonata and Lunesta. Sedating antidepressants (e.g., amitriptyline, trazodone, mirtazapine) have also been used to treat insomnia; however, there is less evidence to support their use for insomnia (Buscemi, 2007) (Morin, 2007), but they may be an option in patients with coexisting depression. There was no mention in the case file of evaluation for insomnia or failure of first line treatment options. This request is not medically necessary and appropriate.

Retro Tramadol 50mg #60 (DOS 09/10/2015): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: The IW has been on long term opioids which is not recommended. Additionally, documentation did not include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The documentation from the date of request notes that the IW's pain is worse. This request is not medically necessary and reasonable.

Retro Omeprazole 20mg #60 (DOS 09/10/2015): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: According to MTUS guidelines it is necessary to determine if the patient is at risk for gastrointestinal events. Risk factors are: (1) age > 65 years; (2) history of peptic

ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). A history of ulcer complications is the most important predictor of future ulcer complications associated with NSAID use. There was no notation of GI symptoms or a history of risk factors. This request is not medically necessary or appropriate.

Retro Anaprox 550mg #60 (DOS 09/10/2015): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, specific drug list & adverse effects.

Decision rationale: According to MTUS guidelines NSAID's are recommended as an option for short-term symptomatic relief of chronic low back pain. Naproxen is a nonsteroidal anti-inflammatory drug (NSAID) for the relief of the signs and symptoms of osteoarthritis. According to the MTUS and ODG guidelines NSAID's are recommended for osteoarthritis, chronic back pain and acute exacerbations of back pain. According to the progress notes provided the IW was on Naproxen with a diagnosis of lumbar radiculopathy. There is inconsistent evidence for the use of these medications to treat long term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions however it is documented that the IW takes the Naproxen daily and that the pain is worse. This request is not medically necessary and appropriate at this time.