MAXIMUS Federal Services

Case Number:	CM15-0211233		
Date Assigned:	10/30/2015	Date of Injury:	04/11/2013
Decision Date:	12/15/2015	UR Denial Date:	10/05/2015
Priority:	Standard	Application Received:	10/27/2015

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, Illinois
Certification(s)/Specialty: Preventive Medicine, Occupational 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 38 year old male, who sustained an industrial injury on 04-11-2013. A review of the medical records indicates that the worker is undergoing treatment for left shoulder strain, persistent neck pain, and left shoulder labral tear status post left shoulder arthroscopy. Treatment has included Ibuprofen (start date unknown), a home exercise program and surgery. Subjective complaints (03-05-2015) included pain near trapezius muscle and reported that left shoulder was better than before surgery. Objective findings showed tenderness to palpation of the cervical spine and posterior periscapular area of the left shoulder with elevation of the arm to 170 degrees. The treatment plan included continued home exercise program. Subjective complaints (09-16-2015) included ongoing left shoulder pain and significant sleep disruption secondary to shoulder pain, however there was no discussion of the injured worker's sleep hygiene, methods tried to improve sleep and the duration and quality of sleep. Ibuprofen was noted to help manage shoulder pain but there were no pain ratings provided before and after the use of medication and duration of pain relief was not documented. No objective examination findings were documented. The physician noted that the worker was being prescribed Trazodone in an effort to help with sleep. Ibuprofen refills were also being requested. A utilization review dated 10-05-2015 non-certified requests for Ibuprofen 800 mg #90 + 2 refills and Trazodone 50 mg #30 + 2 refills with a dos of 09-16-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Ibuprofen 800 mg #90 with 2 refills with a dos of 9/16/2015: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

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

Decision rationale: The injured worker sustained a work related injury on 04-11-2013. The diagnosis include left shoulder strain, persistent neck pain, left shoulder labral tear status post left shoulder arthroscopy. Treatment has included Ibuprofen (start date unknown), a home exercise program and surgery. The medical records provided for review do not indicate a medical necessity for Retro Ibuprofen 800 mg #90 with 2 refills with a dos of 9/16/2015. It is uncertain how long the injured worker has taken this NSAID, but the MTUS recommends the lowest dose of NSAIDs for the shortest period in patients with moderate to severe pain. The MTUS guidelines states that doses greater than 400 mg have not provided greater relief of pain. The requested treatment is not medically necessary since this is not the lowest effective dose; also because of the increased side effects from the use of this dose, including the risk of kidney failure.

Retro Trazodone 50 mg #30 with 2 refills with a dos of 9/16/2015: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress Trazodone (Desyrel).

Decision rationale: The injured worker sustained a work related injury on 04-11-2013. The diagnosis include left shoulder strain, persistent neck pain, left shoulder labral tear status post left shoulder arthroscopy. Treatment has included Ibuprofen (start date unknown), a home exercise program and surgery. The medical records provided for review do not indicate a medical necessity for Retro Trazodone 50 mg #30 with 2 refills with a dos of 9/16/2015. The MTUS is silent on the topic, but the Official Disability Guidelines states that it is recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. Not recommended as a first-line treatment for insomnia in patients generally, or as a first-line treatment for depression or for pain. The medical records indicate the injured worker complains of difficulty sleeping, but there was no documentation of psychiatric complaints, therefore is not medically necessary.