

<b>Case Number:</b>	CM15-0080717		
<b>Date Assigned:</b>	05/01/2015	<b>Date of Injury:</b>	11/30/2010
<b>Decision Date:</b>	06/05/2015	<b>UR Denial Date:</b>	04/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/27/2015

### 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, Florida, California

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 55 year old female who sustained an industrial injury on 11/30/2010. Her diagnoses, and/or impressions, are noted to include: right shoulder pain, articular cartilage injury, status-post SLAP repair (1/2/10) & 10/2/11); and interstitial tear of the rotator cuff supraspinatus with moderate tendinosis and "AC" joint arthrosis (per the 10/17/14 magnetic resonance imaging study). Recent magnetic imaging studies are noted to have been done on 10/17/14. Her treatments have included right shoulder physical therapy; home exercise program; pre-magnetic resonance imaging right shoulder gadolinium joint injection, with magnetic resonance imaging on 10/17/14; medication management; toxicology screenings; psychotherapy; and full duty versus modified work duties versus rest from work. The progress notes of 3/18/2015 reported complains of ongoing, moderate-severe right shoulder pain; and worsening, severe left shoulder pain, from overuse, secondary to right shoulder surgeries. Objective findings are noted to include tenderness throughout the right shoulder area, limited and painful range-of-motion; and tenderness throughout the left shoulder area with diminished and painful range-of-motion; improved with medication. The physician's requests for treatments were noted to include the continuation of Ultracet and Trazadone.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective (DOS: 3/18/15) Zanaflex 4mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 64-66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 64 of 127.

**Decision rationale:** In this case, tenderness is noted, but no acute spasm. Regarding muscle relaxants like Zanaflex, the MTUS recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008). In this case, there is no evidence of it being used short term or acute exacerbation. There is no evidence of muscle spasm on examination. The records attest it is being used long term, which is not supported in MTUS. Further, it is not clear it is being used second line; there is no documentation of what first line medicines had been tried and failed. Further, the MTUS notes that in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. The request is not medically necessary.

**Retrospective (DOS: 3/18/15) Ultracet 325mg #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 93-94, 113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines : Pain interventions and treatments 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 12,13 83 and 113 of 127.

**Decision rationale:** The main component in Ultracet is Tramadol. Per the MTUS, Tramadol is an opiate analogue medication, not recommended as a first-line therapy. The MTUS based on Cochrane studies found very small pain improvements, and adverse events caused participants to discontinue the medicine. Most important, there are no long-term studies to allow it to be recommended for use past six months. A long-term use of is therefore not supported. The request is not medically necessary.

**Retrospective (DOS: 3/18/15) Trazodone 50mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Trazodone.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, under Antidepressants.

**Decision rationale:** The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. Trazodone is an antidepressant medicine. Regarding antidepressants to treat a major depressive disorder, the ODG notes: Recommended for initial treatment of presentations of Major Depressive Disorder (MDD) that are moderate, severe, or psychotic, unless electroconvulsive therapy is part of the treatment plan. Not recommended for mild symptoms. In this case, it is not clear what objective benefit has been achieved out of the antidepressant usage, how the activities of daily living have improved, and what other benefits have been. It is not clear if this claimant has a major depressive disorder as defined in DSM-IV. If used for pain, it is not clear what objective, functional benefit has been achieved. The request is not medically necessary.