

<b>Case Number:</b>	CM15-0091109		
<b>Date Assigned:</b>	05/15/2015	<b>Date of Injury:</b>	10/19/2000
<b>Decision Date:</b>	09/24/2015	<b>UR Denial Date:</b>	04/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/12/2015

### 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: 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 47 year old male, who sustained an industrial injury on October 19, 2000. The mechanism of injury was not provided. The injured worker has been treated for neck, left shoulder and back complaints. The diagnoses have included lumbago, shoulder pain in joint, unspecified disorders of the bursae and tendons of the shoulder region, cervical displacement of the intervertebral disc without myelopathy, cervical degenerative disc disease, cervicalgia, cervical post-laminectomy syndrome and brachial neuritis or radiculitis. Treatment to date has included medications, radiological studies, moist heat, home exercise program, cervical spine fusion and three left shoulder surgeries. Current documentation dated March 24, 2015 notes that the injured worker reported an increase in neck pain and right shoulder pain. The pain was rated an eight out of ten on the visual analogue scale with medications. The medications were noted to keep the injured worker functional, allowing for increased mobility and tolerance of activities of daily living and his home exercise program. Objective findings were not provided in the medical records. The treating physician's plan of care included requests for a cervical MRI without contrast, physical therapy for the left shoulder # 12 and the medications Trazadone HCL 100 mg # 15, Restoril 30 mg # 30, Norco 10/325 mg # 45 and Oxycontin XR 40 mg # 105.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Trazodone HCL (Hydrochloride) 100mg, #15: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants for chronic pain Page(s): 13-14.

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

**Decision rationale:** Trazodone is a tetracyclic antidepressant used to treat depression and anxiety disorders. The Official Disability Guidelines recommend numerous antidepressants in a number of classes for treating depression and chronic pain. Trazodone is not contained within the current recommendations by the ODG. Trazodone HCL (Hydrochloride) 100mg, #15 is not medically necessary.

**Restoril 30mg, #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

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

**Decision rationale:** The Official Disability Guidelines do not recommended benzodiazepines such as Restoril for long-term use because long-term efficacy is unproven and there is a risk of psychological and physical dependence or frank addiction. Most guidelines limit use to 4 weeks. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Restoril 30mg, #30 is not medically necessary.

**Norco 10/325mg, #45: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen; Oxycodone immediate release; Opioids, criteria for use Page(s): 91-92, 78-80, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-94.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of Norco, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 6 months. Norco 10/325mg, #45 is not medically necessary.

**Oxycontin 40mg, XR12H - tablets, #105: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen; Oxycodone immediate release; Opioids, criteria for use; Weaning of Medications Page(s): 91-92, 78-80, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain Page(s): 60.

**Decision rationale:** According to the MTUS in regard to medications for chronic pain, only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. A record of pain and function with the medication should be recorded. According to this citation from the MTUS, medications should not be initiated in a group fashion, and specific benefit with respect to pain and function should be documented for each medication. There is no documentation of the above criteria for either of the narcotics that the patient has been taking. Oxycontin 40mg, XR12H - tablets, #105 is not medically necessary.

**Physical therapy for the left shoulder, 12 sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58.

**Decision rationale:** Therapeutic physical therapy for the low back is recommended by the MTUS as an option with authorization for a trial of 6 visits over 2 weeks, with evidence of objective functional improvement, prior to authorizing more treatments with a total of up to 18 visits over 6-8 weeks. There is no documentation of objective functional improvement and the request is for greater than the number of visits necessary for a trial to show evidence of objective functional improvement prior to authorizing more treatments. Original reviewer modified the request from 12 sessions to 6 sessions. Physical therapy for the left shoulder, 12 sessions is not medically necessary.

**Magnetic resonance imaging (MRI) without contrast, cervical:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177, 178, 182.

**Decision rationale:** The MTUS states that an MRI or CT is recommended to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. In addition, the ACOEM Guidelines state the following criteria for ordering imaging studies: 1. Emergence of a red flag, 2. Physiologic evidence of

tissue insult or neurologic dysfunction, 3. Failure to progress in a strengthening program intended to avoid surgery, 4. Clarification of the anatomy prior to an invasive procedure. There is no documentation of any of the above criteria supporting a recommendation of a cervical MRI. Magnetic resonance imaging (MRI) without contrast, cervical is not medically necessary.