

Case Number:	CM14-0016293		
Date Assigned:	03/07/2014	Date of Injury:	08/06/2008
Decision Date:	07/21/2014	UR Denial Date:	01/21/2014
Priority:	Standard	Application Received:	02/10/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 records presented for review indicate that partial certifications of the medications Hydrocodone and Mirtazapine (a.k.a. Remeron) were completed. It is noted the date of injury is August 2008 and there is constant pain in the right shoulder. It is also noted the injured employee remains anxious and depressed. A slightly decreased shoulder range of motion is noted. The clinical assessment is adhesive capsulitis. There was no documentation of increased functionality, decreased pain or an assessment of the ability to return to work. Thereby the medication was not certified and a weaning protocol was to be established. A follow-up evaluation was completed in July 2013. There were ongoing complaints of pain in the right wrist, decreased grip strength in the right hand, and pain in the right shoulder. The pain level was described as 8/10. The objective findings noted well-healed surgical scars and a slight decrease in motor function. The medication Tramadol was prescribed. Urine drug screening noted the medication Hydrocodone. An MRI of the right wrist was obtained. A tendinitis was identified. A necrosis is also reported. The September 19, 2013, progress note indicated the Ultracet (Tramadol) was ineffective. With this change the pain level is noted to be 7/10. The December 2013 progress report indicated a greater than 50% pain relief with the medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

HYDROCODONE/APAP 7.5/325MG #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines, regarding ongoing management of Opioids, states that prescriptions must be from a single practitioner taken as directed, and all prescriptions from a single pharmacy; the lowest possible dose should be prescribed to improve pain and function; and there must be ongoing 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. In this case, the progress note indicates the medication Tramadol, was noted to be ineffective, however, the urine drug screen indicated that the Hydrocodone had already been imbibed. There is also contradictory information relative to the efficacy of the Hydrocodone as the progress note indicated a 50% improvement, but the pain level continued to be 8/10. There is no noted efficacy objectified with use of this medication. Furthermore, there is no noted increased functionality or ability to return to work. Additionally, the progress note does not address an opioid agreement. Therefore, the requested Hydrocodone/APAP 7.5/325mg # 120 is not medically necessary or appropriate.

MIRTAZAPINE 15MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: In this case, while there is notation of ongoing complaints of pain, there is no objectification of a diagnosis of depression for which Mirtazapine would normally be utilized. As such the anti-depressant is being employed to augment the analgesic medication. The records provided for review show no noted efficacy or utility for this medication and there is no clear objective clinical evidence for the continued need of this intervention. Therefore, the requested Mirtazapine 15 mg #90 is not medically necessary or appropriate.