

<b>Case Number:</b>	CM14-0189014		
<b>Date Assigned:</b>	11/19/2014	<b>Date of Injury:</b>	01/03/2012
<b>Decision Date:</b>	01/08/2015	<b>UR Denial Date:</b>	11/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/12/2014

### 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 Physical Medicine and Rehabilitation 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 patient is a 54 year old male with date of injury on 01/03/2012. The treating physician report dated 07/18/14 indicates that the patient presents with pain affecting the low back, neck, right knee, and both hand. The physical examination findings reveal tenderness and hypertonicity on the lumbar spine and straight leg tests caused pain in the low back, tenderness to the cervical spine, and tenderness in the right knee. The patient rates his pain as 4/10 with medication and 8/10 without medication. The patient is working modified duty. Prior treatment history includes physical therapy, acupuncture, chiropractic therapy, home exercise program, and a lumbar ESI. MRI findings were interpreted by the treating physician who documented multiple levels of disc protrusions, moderate central canal stenosis, at L2-3, and diffused endplate degenerative changes. EMG testing revealed electrical evidence of a mild to moderate diabetic peripheral neuropathy affecting the bilateral upper extremities and mild bilateral carpal tunnel syndrome. The current diagnoses are: 1. Cervical Spine Musculoligamentous Sprain/ Strain with Bilateral Upper Extremity Radiculopathy 2. Lumbar Spine Musculoligamentous Sprain/ Strain with Bilateral Lower Extremity Radiculopathy 3. Right Knee Patellofemoral Arthralgia 4. Bilateral Shoulder Periscapular Musculoligamentous Sprain/ Strain with Rotator Cuffs Tears 5. Stress/ Depression/ Sleep Loss 6. Headaches The utilization review report dated 11/05/14 denied the request for Ultram ER #30, Robaxin 750 mg #120, Remeron 15 mg #30, and sleep study/consult based on guidelines not being met.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultram Extended release #30: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78, 88-89.

**Decision rationale:** The patient presents with pain affecting the low back, neck, right knee, and hand. The current request is for Ultram Extended release #30. The primary treating physician report dated 07/18/14 states "The patient indicates that he can perform some activities independently, but with pain. He can perform some activities but modified or with assistance." For chronic opiate use, the MTUS Guidelines states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." The MTUS also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and aberrant behavior), as well as "pain assessment" or outcome measures. The primary treating physician noted that the patient has a pain reduction while taking the medication and does have some functional improvement in daily activities. There is no mention of side effects, aberrant behavior or any specific descriptions of the analgesia and functional improvements that are achieved with this medication. The MTUS requires much more thorough documentation of the effects of opioids to recommend ongoing usage. The request is not medically necessary.

**Robaxin 750mg #120: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-65.

**Decision rationale:** The patient presents with pain affecting the low back, neck, right knee, and hand. The current request is for Robaxin 750mg #120. The primary treating physician documents multiple complaints of low back pain and on the treating physician's 07/18/14 report; they stated "the patient's ongoing symptoms of low back pain." The MTUS page 63 states the following about muscle relaxants, "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP." In this case the treating physician has not prescribed this medication due to an acute exacerbation and there is no documentation that this medication is for short term usage. This request is not medically necessary.

**Remeron 15mg #30: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Agency of Healthcare Research and Quality National Guideline Clearinghouse <http://www.guideline.gov/content.aspx?id=24158&search=remeron> AETNA Pharmacy Clinical Policy <http://www.aetna.com/products/rxnonmedicare/data/2013/CNS2013/antidepressants.html>

**Decision rationale:** The patient presents with pain affecting the low back, neck, right knee, and hand. The current request is for Remeron 15mg #30. Remeron (Mirtazapine) is a tetracyclic antidepressant used for treatment of major depression and was approved by the FDA in 1996. The MTUS and the ODG guidelines do not address Remeron. The National Guideline Clearinghouse, Practice guideline for the treatment of patients with major depressive disorder does recommend the usage of Remeron. The AETNA Pharmacy Clinical Policy does recommend Remeron for the treatment of depression. In this case the patient was diagnosed with Bipolar disorder with moderate to severe depression and the treating physician has prescribed Remeron. This request appears to be for an initial request for this medication and the guidelines cited above support Remeron for the treatment of major depression. The request is considered medically necessary.

**Sleep consult /study:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Insomnia Treatment.

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

**Decision rationale:** The patient presents with pain affecting the low back, neck, right knee, and hand. The current request is for Sleep consult /study. The primary treating physician has multiple documents of the patient not being able to sleep due to pain. The primary treating physician's report dated 07/18/14 not only diagnosed the patient as having sleep loss, but also noted the patient as being depressed. The patient was sent to a psychologist who stated that the patient "has sustained an industrial injury to his psyche." The ODG guidelines state: "Recommended after at least six months of an insomnia complaint (at least four nights a week), unresponsive to behavior intervention and sedative/sleep-promoting medications, and after psychiatric etiology has been excluded. Not recommended for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders." In this case the patient has significant issues with chronic pain and psychiatric disorder. The treating physician has not documented behavior interventions and response to sedative/sleep-promoting medications per guideline recommendations. The study requested is not medically necessary.