MAXIMUS Federal Services

Case Number:	CM14-0193874		
Date Assigned:	12/01/2014	Date of Injury:	12/01/2006
Decision Date:	01/14/2015	UR Denial Date:	10/21/2014
Priority:	Standard	Application Received:	11/19/2014

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 Internal Medicine, has a subspecialty in Nephrology 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:

This is a 56-year-old female with a 12/1/06 date of injury. According to a progress report dated 10/16/14, the patient stated that her pain has not changed for 10 years. She has still been functioning as is, but her presentation varies each time, and she reported that each time her pain was worse than the last visit in the past 10 years. She may take more Percocet due to her activities, up to 5, but was instructed to only take 3 per day. She complained of bilateral forearm pain, with her tendinitis problems. She had some more difficulty with movement and activities of daily living due to her upper extremity pain and symptoms. Objective findings: full, active shoulder range of motion; tenderness to palpation of bilateral forearms and palms; deep and focal palpation of muscle knots elicited classic twitch response with slight radiation pattern consistent with trigger point radiation pattern. Diagnostic impression: chronic pain syndrome, tenosynovitis of hand and wrist, myalgia and myositis, disorders of bursae and tendons in shoulder region, lumbago, displacement of lumbar intervertebral disc without myelopathy, thoracic or lumbosacral neuritis, insomnia. Treatment to date: medication management, activity modification.A UR decision dated 10/21/14 denied the requests for Opana ER, Percocet, and mirtazapine. A specific rationale was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Opana ER 20mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines criteria for use for a therapeutic trial of opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiates Page(s): 78-81.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. However, in the medical records provided for review, there is no documentation of significant pain reduction or improved activities of daily living. In the fact, the patient indicated that her pain has not changed in the past 10 years, despite the use of medication. Guidelines do not support the continued use of opioid medications without documentation of functional improvement. In addition, given the 2006 date of injury, the duration of opiate use to date is not clear. There is no discussion regarding non-opiate means of pain control, or endpoints of treatment. Furthermore, according to the patient's opioid medication regimen, the patient's daily MED is calculated to be 165. Guidelines do not support daily MED above 120 due to the risk of adverse effects, such as sedation and respiratory depression. Therefore, the request for Opana ER, #60 was not medically necessary.

Percocet 10/325mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines criteria for use for a therapeutic trial of opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiates Page(s): 78-81.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. However, in the medical records provided for review, there is no documentation of significant pain reduction or improved activities of daily living. In the fact, the patient indicated that her pain has not changed in the past 10 years, despite the use of medication. Guidelines do not support the continued use of opioid medications without documentation of functional improvement. In addition, given the 2006 date of injury, the duration of opiate use to date is not clear. There is no discussion regarding non-opiate means of pain control, or endpoints of treatment. Furthermore, according to the patient's opioid medication regimen, the patient's daily MED is calculated to be 165. Guidelines do not support daily MED above 120 due to the risk of adverse effects, such as sedation and respiratory depression. Therefore, the request for Percocet 10/325mg, #90 was not medically necessary.

Mirtazapine 15mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13-14. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter - Antidepressants and on Other Medical Treatment Guideline or Medical Evidence: FDA (Remeron)

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. In addition, ODG identifies that anxiety medications in chronic pain are recommend for diagnosing and controlling anxiety as an important part of chronic pain treatment. According to the FDA, Remeron (mirtazapine) is an antidepressant. Mirtazapine affects central noradrenergic and serotonergic activity in the brain that may become unbalanced and cause depression. However, in the present case, there is no documentation that the patient has a diagnosis or complaints of depression. A specific rationale as to why mirtazapine is indicated in this patient was not provided. Therefore, the request for Mirtazapine 15mg, #60 was not medically necessary.