

Case Number:	CM14-0206074		
Date Assigned:	12/18/2014	Date of Injury:	12/01/2006
Decision Date:	02/12/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	12/09/2014

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 Rehab 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 56 year old female with date of injury 12/01/06. The treating physician report dated 11/12/14 indicates that the patient presents with pain affecting bilateral forearm pain, right shoulder, left thigh, and lower back. The physical examination findings reveal pain with resistive testing of shoulders/arms/wrists, and deep muscle and focal palpation of the muscle knots elicited twitch response with slight radiation pattern. Prior treatment history includes failed LESI, QME, physical therapy, negative sleep study, shoulder injection, and medications. The current diagnoses are: 1. Pain in Limb2. Tenosynovitis3. Myofascial Pain Syndrome4. Syndrome, Rotator Cuff 5. Chronic Pain Syndrome6. Lumbago7. Insomnia The utilization review report dated 11/18/14 denied the request for Percocet 10mg, Mirtazapine 30mg, Gabapentin 300mg, and Lorazepam 2mg based on guidelines not being met (23).

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10mg: Upheld

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

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

Decision rationale: The patient presents with pain affecting bilateral forearm pain, right shoulder, left thigh, and lower back. The current request is for Percocet 10mg. The treating physician states, "With medications, she can do something, her ADL, drive, go to church. She can do exercise and shopping on her own, at times using an electric cart." (88) The MTUS guidelines for ongoing opioid usage state "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS also require documentation of the 4As (analgesia, ADLs, adverse side effects, and aberrant behavior), as well as a "pain assessment." In this case, the treating physician has documented that the patient is able to perform some ADLs but did not document if the patient was having any side effects, analgesia, or aberrant behavior. The MTUS guidelines require much more thorough documentation for continued opioid usage. The current request does not specify the quantity, frequency or duration of the prescription, thus rendering this request as an invalid prescription. Therefore, the request is not medically necessary.

Mirtazapine 30mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain. Page(s): 13-15.

Decision rationale: The patient presents with pain affecting bilateral forearm pain, right shoulder, left thigh, and lower back. The current request is for Mirtazapine 30mg. The treating physician states, "2 tablets at bed time." "Recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. (Feuerstein, 1997) (Perrot, 2006) Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur." In this case, the treating physician provided no discussion as to what this medication is being prescribed for. It would appear that it's used for the patient's chronic pain, depressions and/or insomnia which may be appropriate. However, the primary treating physician does not discuss efficacy. There is no explanation as to how this medication is effective in managing any of the patient's current condition. MTUS page 60 require documentation of pain and function when medications are used for chronic pain. The current request does not specify the quantity, frequency or duration of the prescription, thus rendering this request as an invalid prescription. Therefore, the request is not medically necessary.

Gabapentin 300mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 49.

Decision rationale: The patient presents with pain affecting bilateral forearm pain, right shoulder, left thigh, and lower back. The current request is for Gabapentin 300mg. The primary treating physician states, "She also complained of sharp pain going down her left anterior thigh." (88) The MTUS guidelines state "effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain". In this case the treating physician has documented that the patient has complaints of paresthesia affecting the right upper extremity. While this medication may be beneficial for the patient, the current request does not specify the frequency or duration of the prescription, thus rendering this request as an invalid prescription. Therefore, the request is not medically necessary.

Lorazepam 2mg: Upheld

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

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

Decision rationale: The patient presents with pain affecting bilateral forearm pain, right shoulder, left thigh, and lower back. The current request is for Lorazepam 2mg. The treating physician states, "2 oral tablets 3 times a day." (90) The MTUS guidelines state, "Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks." In this case, the treating physician has been prescribing this medication since at least June 2014 which would exceed the recommended guidelines. The current request does not specify the frequency or duration of the prescription, thus rendering this request as an invalid prescription. Therefore, the request is not medically necessary.