

Case Number:	CM14-0208696		
Date Assigned:	12/22/2014	Date of Injury:	12/11/2002
Decision Date:	02/27/2015	UR Denial Date:	11/14/2014
Priority:	Standard	Application Received:	12/12/2014

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. 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: Arizona, California, Florida
 Certification(s)/Specialty: Family Practice

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 a 54-year-old female who reported injury on 12/11/2002. The mechanism of injury was not submitted for review. The injured worker has diagnoses of: status post bilateral carpal tunnel surgery; decreased sensation right median, left median, and ulnar nerve distribution; status post bilateral rotator cuff repairs; and left medial epicondylitis. The injured worker's past surgical history consists of left shoulder arthroscopy revision rotator cuff repair, left shoulder acromioplasty, and right shoulder rotator cuff tendon repair. No UAs or drug screens were submitted for review. Past medical treatment consists of surgery, physical therapy, behavioral therapy, and medication therapy. Medications consist of gabapentin 300 mg, Dilaudid 2 mg, Paxil 40 mg, Zanaflex 4 mg, Cozaar 50 mg, and Seroquel 50 mg. On 09/24/2014, the injured worker complained of left and right shoulder pain. The physical examination revealed that the left shoulder had well healed arthroscopic portal sites. Forward flexion was 45 degrees; external rotation was to 30 degrees. Abduction was 110 degrees. Rotator cuff strength was 4+/5. Examination of the right shoulder had marked crepitus. Forward elevation was to 125 degrees, external rotation was to 30 degrees, and internal rotation was to L5. Abduction strength was 4-/5. The treatment plan was for the injured worker to continue with physical therapy and medication therapy. Rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Paxil 40mg #30 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SSRIs (selective serotonin reuptake inhibitors) Page(s): 107.

Decision rationale: The request for Paxil 40mg #30 with 3 refills is not medically necessary. The California MTUS Guidelines do not recommend the use of SSRIs for the treatment of chronic pain, but SSRIs may be used in treating secondary depression. SSRIs, a class of antidepressants that inhibit serotonin reuptake without action on noradrenaline, are controversial based on controlled trials. It has been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain. The submitted documentation did not indicate that the injured worker had a diagnosis of secondary depression. Additionally, it is unclear as to how long the injured worker has been taking the medication. Furthermore, there was no rationale submitted for review to warrant the request. Given the above, the injured worker is not within recommended guideline criteria. As such, the request is not medically necessary.

Dilaudid 2mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 78.

Decision rationale: The request for Dilaudid 2mg #90 is not medically necessary. The California MTUS Guidelines recommend providing ongoing education on both the benefits and limitations of opioid treatment. The guidelines recommend the lowest possible dose should be prescribed to improve pain and function. They also state that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be submitted for review. A pain assessment should include: current pain, the least reported pain over the period since the 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. The submitted documentation did not indicate the efficacy of the medication, nor did it indicate that it was helping with any functional deficits the injured worker might have had. Additionally, there were no UAs or drug screens submitted for review showing that the injured worker was compliant with medication treatment. Furthermore, the request as submitted did not indicate a frequency or duration of the medication. Given the above, the injured worker is not within recommended guideline criteria. As such, the request is not medically necessary.

