

Case Number:	CM15-0100975		
Date Assigned:	06/03/2015	Date of Injury:	07/08/2010
Decision Date:	07/03/2015	UR Denial Date:	04/27/2015
Priority:	Standard	Application Received:	05/26/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 46-year-old female, who sustained an industrial injury on 7/8/10. The injured worker was diagnosed as having synovitis/tenosynovitis of the hand and wrist joint pain. Treatment to date has included TENS, occupational therapy, a home exercise program, and medication. The injured worker had been taking Ketoprofen, Mirtazapine, and Tramadol since at least 10/20/14. Currently, the injured worker complains of bilateral arm and hand pain left greater than right. Bilateral upper extremity numbness and tingling were also noted. The treating physician requested authorization for Tramadol 50mg #90 with 5 refills, Mirtazapine 7.5mg #30 with 5 refills, and Ketoprofen 75mg #60 with 5 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50mg #90 with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Medication Page(s): 75-80.

Decision rationale: Regarding the request for Tramadol, Chronic Pain Medical Treatment Guidelines state that Tramadol is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS). The provider stated that the patient has no risk for aberrant use; however, there is no CUREs report or urine drug screen to support this statement. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Tramadol is not medically necessary.

Mirtazapine 7.5mg #30 with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 14.

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 Chapter & Mental Illness and Stress Chapter, Insomnia Topics.

Decision rationale: Regarding the request for Mirtazapine, California MTUS guidelines are silent regarding the use of sedative hypnotic agents. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there is a subjective complaint of insomnia. However, there is no discussion regarding how frequently the insomnia complaints occur or how long they have been occurring, no statement indicating what behavioral treatments have been attempted for the condition of insomnia, and no statement indicating how the patient has responded to Mirtazapine treatment. Given this, the currently requested Mirtazapine is not medically necessary.

Ketoprofen 75mg #60 with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medication Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-72.

Decision rationale: Regarding the request for Ketoprofen, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that Ketoprofen is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale), or any objective functional improvement. In the absence of such documentation, the currently requested Ketoprofen is not medically necessary.