

Case Number:	CM15-0148706		
Date Assigned:	08/12/2015	Date of Injury:	02/11/2009
Decision Date:	09/17/2015	UR Denial Date:	07/10/2015
Priority:	Standard	Application Received:	07/31/2015

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: New Jersey, New York
 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 60 year old female, who sustained an industrial injury on 2-11-09. The injured worker was diagnosed as having chronic regional pain syndrome of the upper extremity, muscle spasm, and sprain and strain of the sacroiliac region. Treatment to date has included injections, treatment with a psychiatrist, and medication. On 6-24-15 pain was rated as 5 of 10 at best and 10 of 10 at worst. Currently, the injured worker complains of right arm and neck pain. The treating physician requested authorization for Seroquel 25mg #120, Lorazepam 0.5mg #45, Percocet 10-325mg #120, and Abilify 5mg #120.

IMR ISSUES, DECISIONS AND RATIONALES

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

Seroquel 25mg #120: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Seroquel (Quetiapine) mental/stress.

Decision rationale: The request is considered not medically necessary. MTUS guidelines do not address the use of Seroquel. According to ODG guidelines, Seroquel is not first-line treatment. Atypical antipsychotics are not usually recommended for conditions included in the ODG. The patient suffered from depression however, this was not controlled by her current medication regimen. Therefore, the request is not medically necessary.

Lorazepam 0.5mg #45: 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 request for Ativan is not medically necessary. Ativan is a benzodiazepine, which is not recommended for long-term use because of lack of evidence. They are used as sedative/hypnotics, anxiolytics, anticonvulsants, and muscle relaxants. There is a risk of physical and psychological dependence and addiction to this class. Guidelines limit the use to four weeks which the patient has exceeded. The patient suffered from depression more than anxiety. Therefore, the request is considered not medically necessary.

Percocet 10/325mg #120: 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): 78-79.

Decision rationale: The request is not medically necessary. The chart does not provide any recent objective documentation of improvement in function with the use of percocet. There were no urine drug screens, drug contracts, or documented long-term goals for treatment. The 4 A's of ongoing monitoring were not adequately documented. The patient continued with pain despite current regimen. Therefore, the request is considered not medically necessary.

Abilify 5mg #120: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Aripiprazole, and Mental/Stress.

Decision rationale: The request is considered not medically necessary. MTUS guidelines do not address the use of Abilify. The patient was started on Abilify to improve depressive

symptoms. According to ODG, Abilify can be used as adjunct second-line therapy for bipolar maintenance and major depressive disorder which the patient suffered from due to chronic pain. Psychiatric follow-up was recommended. The patient's depression persisted despite therapy with Abilify and there was no functional improvement. Therefore, the request for Abilify is considered not medically necessary.