

Case Number:	CM15-0208413		
Date Assigned:	10/27/2015	Date of Injury:	10/15/2007
Decision Date:	12/31/2015	UR Denial Date:	10/07/2015
Priority:	Standard	Application Received:	10/22/2015

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: Arizona, Michigan
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 57 year old female, who sustained an industrial injury on 10-15-2007. The injured worker is currently off duty. Medical records indicated that the injured worker is undergoing treatment for neck sprain-strain, cervical spondylosis without myelopathy, sleep disturbance, dysthymic disorder, gastroesophageal reflux disease, and partial tear of rotator cuff. Treatment and diagnostics to date has included surgeries, physical therapy, home exercise program, Toradol injections, and medications. Recent medications have included Naprosyn, Mirtazapine (since at least 08-21-2015), Colace, Zofran, Hydrochlorothiazide, Phenergan, Zoloft, Lovastatin, Losartan, Ranitidine, and Lidocaine ointment. Subjective data (08-21-2015 and 09-21-2015), included chronic neck and left shoulder pain rated 5-6 out of 10 on the pain scale. Objective findings (09-21-2015) included tenderness to cervical and thoracic spine, decreased range of motion to lumbosacral spine and left shoulder, and spasmodic left piriformis muscle. The Utilization Review with a decision date of 10-07-2015 non-certified the request for Dilaudid 2mg ½ tablet every day #10, Mirtazapine 15mg every night #30, Celebrex 200mg one every day #30, and trigger point injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

Dilaudid 2 mg 1/2 tablet every day #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: Per the MTUS, opioids should be discontinued if there is no overall improvement in function, unless there are extenuating circumstances, Opioids should be continued if the patient has returned to work or has improved functioning and pain. Ongoing management actions should include prescriptions from a single practitioner, taken as directed and all prescriptions from a single pharmacy. The lowest possible dose should be prescribed to improve pain and function. Documentation should follow the 4 A's of analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. Long term users of opioids should be regularly reassessed. In the maintenance phase the dose should not be lowered if it is working. Also, patients who receive opioid therapy may sometimes develop unexpected changes in their response to opioids, which includes development of abnormal pain, change in pain pattern, persistence of pain at higher levels than expected when this happens opioids can actually increase rather than decrease sensitivity to noxious stimuli. It is important to note that a decrease in opioid efficacy should not always be treated by increasing the dose or adding other opioids, but may actually require weaning. A review of the injured workers medical records do not reveal documentation of pain and functional improvement with the use of Dilaudid, rather it appears that the injured worker is continuing to have escalating pain, it does not appear that the injured worker is having a favorable response to this treatment. Ongoing management actions as required by the guidelines were also not discussed. Therefore the request for Dilaudid 2 mg 1/2 tablet every day #10 is not medically necessary.

Mirtazapine 15 mg every night #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Web, Pain section.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain. Decision based on Non-MTUS Citation Up-To- Date / Mirtazapine.

Decision rationale: Per the MTUS, antidepressants are recommended as a first line option in the treatment of neuropathic pain and also possibly for non- neuropathic pain. Per Up-To-Date, Mirtazapine is an Alpha-2 Antagonist Antidepressant, however a review of the injured workers medical records that are available do not reveal a clear rationale for the use of this medication neither was there any benefit described from the use of this medication, without this information medical necessity is not established. Therefore the request for Mirtazapine 15 mg every night #30 is not medically necessary.

Celebrex 200 mg on every day #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: Per the MTUS, NSAIDs and COX-2 NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008) Clinicians should weigh the indications for NSAIDs against both GI and cardiovascular risk factors according to specific criteria listed in the MTUS and a selection should be made based on this. However a review of the injured workers medical records do not reveal a clear rationale for the choice of this medication in this injured worker, without this information medical necessity is not established, therefore the request for Celebrex 200 mg on every day #30 is not medically necessary.

Trigger point injections: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Trigger point injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Trigger point injections.

Decision rationale: Per the MTUS, Trigger point injections are recommended only for myofascial pain syndrome as indicated below, with limited lasting value. Not recommended for radicular pain. Trigger point injections with an anesthetic such as bupivacaine are recommended for non-resolving trigger points, but the addition of a corticosteroid is not generally recommended. A trigger point is a discrete focal tenderness located in a palpable taut band of skeletal muscle, which produces a local twitch in response to stimulus to the band. Trigger points may be present in up to 33-50% of the adult population. Myofascial pain syndrome is a regional painful muscle condition with a direct relationship between a specific trigger point and its associated pain region. These injections may occasionally be necessary to maintain function in those with myofascial problems when myofascial trigger points are present on examination. Not recommended for typical back pain or neck pain. Per the MTUS, Criteria for the use of Trigger point injections: Trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended. Unfortunately a review of the injured workers medical records do not reveal that the injured worker meets the criteria for trigger point injections per the guidelines, therefore the request for Trigger Point Injections is not medically necessary.