

Case Number:	CM15-0023012		
Date Assigned:	02/12/2015	Date of Injury:	02/09/2001
Decision Date:	04/07/2015	UR Denial Date:	01/26/2015
Priority:	Standard	Application Received:	02/06/2015

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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 63-year-old female who reported an injury on 02/09/2001 due to an unspecified mechanism of injury. On 01/26/2015, she presented for a follow-up evaluation, reporting neck pain, right hip pain, and low back pain. It was noted that she was not using any medications and requested a prescription for Relafen. It was also noted that she continued to have significant depression. Her medications were listed as gabapentin 600 mg, orphenadrine ER 100 mg, Nexium 40 mg, Ropinirole 1 mg, Colace 100 mg, Remeron 45 mg, levothyroxine 100 mcg, Zocor 40 mg, Coreg 6.5 mg, Pristiq ER 100 mg, trazodone HCl 100 mg, Seroquel 400 mg, isosorbide 300 mg, Lasix 20 mg, famotidine 40 mg, Valium 5 mg, and naltrexone 5 mg. A physical examination of the cervical spine showed tenderness in the upper facets more so on the right, with significantly limited range of motion. There was also tenderness noted in the upper facets more so on the right and range of motion was significantly limited in all fields. Lower extremity and upper extremity strength was noted to be a 5/5 throughout. There was also tenderness in the right greater trochanter and pain with external rotation, and limited external rotation of the hip. She was diagnosed with low back pain; chronic pain syndrome; history of L2-5 anterior posterior fusion; cervical discogenic disease versus cervical facetogenic disease; severe psychiatric depression; history of detoxification from narcotics and narcotic abuse; and right trochanteric bursitis. The treatment plan is for Seroquel XR 300 mg #28. The rationale for treatment was not stated.

IMR ISSUES, DECISIONS AND RATIONALES

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

Seroquel XR 300mg #28: Upheld

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

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

Decision rationale: The Official Disability Guidelines state that antipsychotic medications are not recommended as a first line therapy treatment option, and also state that there is insufficient evidence to justify their use for conditions in the Official Disability Guidelines. The documentation provided did not state a clear rationale for the medical necessity of the medication Seroquel XR. Also, her response to this medication in terms of increase in function and a decrease in pain was not stated. Furthermore, the frequency of the medication was not stated within the request. Therefore, the request is not supported. As such, the request is not medically necessary.