

Case Number:	CM14-0124969		
Date Assigned:	09/16/2014	Date of Injury:	12/01/2008
Decision Date:	10/16/2014	UR Denial Date:	07/31/2014
Priority:	Standard	Application Received:	08/07/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine Pain Management and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 56 year old female with an injury date of 12/01/08. Based on the 07/25/14 progress report, the patient complains of pain in her leg, low back, hands, bilateral forearms, and right shoulder. She has tenderness to palpation of her left shoulder, bilateral forearms, and palms. She has difficulty extending from a flexed position and with pain. Muscle examination reveals firm muscle knots in her trapezius, scalene, supraspinatus, infraspinatus, teres, rhombic pectoralis, upper quadrant, and paralumbar muscle groups. Deep and focal palpation of the muscle knots elicits twitch response with radiation patterns which are consistent with trigger point radiation patterns. "She has some more difficulty with movement and ADL due to her upper extremity pain and symptoms." The patient is currently taking Opana ER and Percocet. The patient's diagnoses include the following: 1.Chronic pain syndrome2.Other tenosynovitis or hand and wrist3.Myalgia and myositis, unspecified4.Pain in limb5.Disorders of bursae and tendons in shoulder region, unspecified6.Lumbago7.Displacement of lumbar intervertebral disc without myelopathythe utilization review determination being challenged is dated 07/31/14. Treatment reports were provided from 03/04/14- 07/25/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Opana ER 20mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain, CRITERIA FOR USE OF OPIOIDS Page(s): 60,61, 88, 89.

Decision rationale: According to the 07/25/14 progress report, the patient complains of pain in her leg, low back, hands, bilateral forearms, and right shoulder. The request is for Opana ER 20 mg. She has been taking this medication as early as 11/01/10. The 07/25/14 report states that "With medications, she can do something, her ADL, drive, go to church. She can do exercise and shopping on her own, at times using an electric cart." Her 02/24/14 UDS shows that she is consistent with her prescription use. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. In this case, the provider does not discuss any adverse side effects, and adverse behavior. No drug screens are discussed. There are no pain scales or other scales measuring the patient's pain and function to show significant difference. No "pain assessment" measures are provided as required by MTUS. Therefore, this request is not medically necessary.

Percocet 10/325mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain CRITERIA FOR USE OF OPIOIDS Page(s): 60,61, 88, 89.

Decision rationale: According to the 07/25/14 progress report, the patient complains of pain in her leg, low back, hands, bilateral forearms, and right shoulder. The request is for Percocet 10/325 mg. She has been taking this medication as early as 08/16/07. The 07/25/14 report states that "With medications, she can do something, her ADL, drive, go to church. She can do exercise and shopping on her own, at times using an electric cart." Her 02/24/14 UDS shows that she is consistent with her prescription use. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. In this case, the provider does not discuss any adverse side effects/behavior. There is no pain scales provided either. Therefore, this request is not medically necessary.

Mirtazapine 15mg: 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) ODG guidelines have the following regarding Remeron for insomnia: Sedating antidepressants (e.g., amitriptyline, trazodone, mirtazapine) have also been used to treat insomnia; however, there is less evidence to support their use for insomnia (Buscemi, 2007) (Morin, 2007), but they may be an option in patients with coexisting depression.

Decision rationale: According to the 07/25/14 progress report, the patient complains of pain in her leg, low back, hands, bilateral forearms, and right shoulder. The request is for Mirtazapine 15 mg. She has been taking this medication as early as 12/18/08. MTUS and ACOEM Guidelines do not discuss this medication. Therefore, ODG Guidelines were referenced. ODG Guidelines has the following regarding Remeron for insomnia; "Sedating antidepressants (amitriptyline, Trazodone, and mirtazapine) have also been used to treat insomnia; however, there is less evidence to support their use for insomnia, but they may be an option for patients with coexisting depression." Review of the reports does not indicate that the patient has sleep disturbance. There is no discussion provided as to how the patient is doing with the medication compared to before taking the medication. There is also no indication of how mirtazapine has helped the patient's every day function. MTUS page 60 requires discussion of pain/function for medication use to treat chronic pain. Given the lack of documentation regarding the medication's efficacy in terms of daily activity, therefore, this request is not medically necessary.