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| Case Number: | CM14-0214498 | | |
| Date Assigned: | 01/07/2015 | Date of Injury: | 07/02/2007 |
| Decision Date: | 02/28/2015 | UR Denial Date: | 11/25/2014 |
| Priority: | Standard | Application Received: | 12/22/2014 |

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. 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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, 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:

54-year-old male injured worker with date of injury 7/2/07 with related right arm pain. Per progress report dated 11/10/14, the injured worker reported right medial forearm numbness and weakness as well as difficulties sleeping secondary to pain and position. He rated his pain 8/10 with medication and 9/10 without. Per physical exam, there was tenderness and spasm of the paravertebral musculature, positive axial compression, decreased active range, right elbow tenderness to palpation over the medial epicondyle, positive Tinel's at the ulnar groove, decreased sensation at the forearm, fourth, and fifth digits, right hand atrophy of the hypothenar pad and first web space radiating to the third interosseus, and Froment's test positive. Treatment to date has included physical therapy and medication management. The date of UR decision was 11/24/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription of Remeron 15mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Insomnia treatment

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Insomnia Treatment.

Decision rationale: Per the ODG guidelines with regard to insomnia treatment: 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. The documentation submitted for review does not indicate that the injured worker has depression. The request is not medically necessary.