

Case Number:	CM13-0052787		
Date Assigned:	12/30/2013	Date of Injury:	07/21/2011
Decision Date:	03/14/2014	UR Denial Date:	10/25/2013
Priority:	Standard	Application Received:	11/16/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice 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 physician 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 26-year-old male who reported an industrial injury on 07/21/2011, which resulted in a fracture of the femur and subsequently is status post ORIF. The patient reportedly has received postoperative rehabilitation physical therapy sessions. Physical therapy progress notes document functional improvement. On physical examination on 08/25/2011, the patient reported pain to the left knee radiating to the hip and the he patient was prescribed Norco for pain. On 09/01/2011, request for 16 sessions of physical therapy for the leg and a self-directed home exercise program was prescribed. On 11/29/2011, the patient was status post intramedullary rodding of the femur done on 07/21/2011. The objective findings were a nonantalgic gait, TTP left greater trochanter, 4/5 motor strength, improved atrophy of the quadriceps, knee with TTP laterally and no swelling or effusion. The treatment plan at that time was to include 6 more physical therapy sessions for strengthening, conditioning, and integration of the home exercise program. On examination on 10/16/2013, the patient reported low back pain radiating to the lower left extremity. The patient also reported stiffness and tightness in the low back. EMG/NCS studies were normal. The requests were previously reviewed and denied on 10/25/2013 on the basis that the clinical information provided for review lacked medical necessity. The MRI dated 04/15/2013 revealed a posterior horn of the medial meniscus tear, degenerative changes also of the anterior horn of the medial meniscus as well as anterior/posterior horn of the lateral meniscus, and tendinosis of the posterior cruciate ligament; partial tear was not excluded. It is noted that surgery requested for left knee operative arthroscopy, meniscectomy, lateral retinacular release, and medial capsular imbrication was denied. The patient has also had other therapies which included cortisone injections, all of which gave no significant relief. Initial psychiatric evaluation report dated 05/03/2013 indicated the patient meets criteria for the diagnosis of major depressive disorder, single episode, and

moderate insomnia as evidenced by a depressed mood and loss of libido; early mental and late insomnia; impaired concentration of memory, increased appetite and weight gain, worthlessness and guilt of feelings, low energy and fatigue, irritability and anger, hopelessness and helplessness, anxiety with somatic and visceral symptoms, and thoughts of death (not suicidal). These symptoms are impairing the patient's daily functioning, which is reflected in his GAF score of 51.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazodone 50mg #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22, 67-68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain Page(s): 13.

Decision rationale: The California MTUS Guidelines recommend antidepressants for chronic pain and as an option for non-neuropathic pain. The request for Trazodone 50 mg is certified. The results of the initial psychiatric evaluation and the psychological symptomatology presented a diagnosis of major depressive disorder, single episode, and moderate insomnia, impairing the patient's daily functioning which was reflected in the GAF score of 51; as such, the request for the Trazodone is certified.

Effexor 75mg bid #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines (ODG) - Pain Chapter. Page(s): 22,.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 45.

Decision rationale: The California MTUS Guidelines recommend Effexor as an option in first-line treatment of neuropathic pain, and as a possibility for non-neuropathic pain. The request for Effexor 75 mg is certified. The results of the initial psychiatric evaluation and the psychological symptomatology presented a diagnosis of major depressive disorder, single episode, and moderate insomnia, impairing the patient's daily functioning which was reflected in the GAF score of 51; as such, the request for the Effexor is certified.