

Case Number:	CM13-0068030		
Date Assigned:	01/03/2014	Date of Injury:	01/30/2004
Decision Date:	06/02/2014	UR Denial Date:	12/12/2013
Priority:	Standard	Application Received:	12/18/2013

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 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 injured worker is a 60-year-old female who reported an injury on 01/30/2004, secondary to a fall. Current diagnoses include localized primary osteoarthritis of the left leg, joint pain in the left leg, lateral meniscus tear, medial meniscus tear, joint replacement of the hip, and pelvic joint pain. The latest physician progress report submitted for this review is documented on 10/11/2013. The injured worker reported persistent pain in the left thigh and knee with radiation to the hip. Physical examination revealed limited left hip range of motion with swelling. Radiographs obtained in the office on that date indicated an intact hip prosthesis. Treatment recommendations at that time included baseline ESR and CRP testing.

IMR ISSUES, DECISIONS AND RATIONALES

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

SEROQUEL 100MG TAB, #60 X1 REFILL: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mosby's Drug Consult, and the ODG.

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 & Stress Chapter, Quetiapine.

Decision rationale: Official Disability Guidelines state Seroquel is not recommended as first line treatment. There is insufficient evidence to recommend atypical antipsychotics for conditions covered in the Official Disability Guidelines. The medical necessity for an atypical antipsychotic medication has not been established. There is no evidence of a mental status examination. There is no frequency or quantity listed in the current request. As such, the request is not medically necessary and appropriate.

TRAZADONE 100MG PO QHS (50MG X60): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Mental Illness & Stress Procedure Summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

Decision rationale: The MTUS Chronic Pain Guidelines recommend antidepressants as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Official Disability Guidelines recommend Trazodone as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. The injured worker does not maintain a diagnosis of depression or anxiety. Therefore, the medical necessity for the requested medication has not been established. There is no mention of chronic insomnia or sleep disturbance in the medical records provided for review. Based on the clinical information received, the request is not medically necessary and appropriate.