

Case Number:	CM14-0028260		
Date Assigned:	06/13/2014	Date of Injury:	04/25/2012
Decision Date:	07/16/2014	UR Denial Date:	02/21/2014
Priority:	Standard	Application Received:	03/05/2014

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 Occupational Medicine 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 female with date of injury 4/25/2012. Per primary treating physician's progress report dated 1/19/2014, the injured worker had three injections to right knee per one provider, and saw another provider who suggested surgery of her low back. She also fell two weeks ago due to dizziness, bad knee and bad back. On exam right knee has mild tenderness and pain with range of motion. Left knee is reported as same. Back has moderate lumbosacral tenderness. She uses a cane to help her ambulate. Her diagnoses include 1) osteoarthritis of knee and hip 2) rotator cuff (capsule) tear 3) meniscus tear of knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETRO ZOLOFT 50 MG 1 PO QHS: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain section, page(s) 13-16 Page(s): 13-16.

Decision rationale: The injured worker has knee and low back pain and has treatment with medications and knee injections. Depression was not addressed by the requesting physician. It is noted in review of an AME conducted one year prior that the injured worker been diagnosed

with depression that began following her injury. She has been treated with Zoloft for over a year. She has Axis I diagnoses of 1) dysthymic disorder 2) pain disorder associated with both psychological factors and a general medical condition. Antidepressant for chronic pain are recommended by the MTUS guidelines as a first line option for neuropathic pain and as a possibility of non-neuropathic pain. Selective serotonin reuptake inhibitor (SSRIs) such as Zoloft are effective at addressing psychological symptoms associated with chronic pain. Per the AME in January 2013, the psychological symptoms that the injured worker is experiencing is a result of her work related injury. Continued treatment with Zoloft is possibly necessary, however, there is no current assessment of the continued need of Zoloft, and the request does not specify the number of tablets or duration of treatment being requested. Without this information it is not possible to verify the medical necessity of this request. The request for retro Zoloft 50 mg 1 PO QHS is determined to not be medically necessary.

RETRO TRAZEDONE 50MG PO QHS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain.

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

Decision rationale: Trazodone is not addressed by the MTUS guidelines. Per the ODG sedating antidepressants such as trazodone have been used to treat insomnia, however there is less evidence to support their use for insomnia. Trazodone may be an option for patients with coexisting depression. Per the AME in January 2013, the psychological symptoms that the injured worker is experiencing is a result of her work related injury. Continued treatment with trazodone is possibly necessary, however, there is no current assessment of the continued need of trazodone. The benefits for sleep and depression in this particular injured worker are not addressed, and the request does not specify the number of tablets or duration of treatment being requested. Without this information it is not possible to verify the medical necessity of this request. The request for retro trazodone 50 mg PO QHS is determined to not be medically necessary.

RETRO GABAPENTIN 60 MG 1 PO TID: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18,19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy Drugs (AEDs).

Decision rationale: It is noted that the injured worker has been treated chronically with gabapentin. The MTUS guidelines recommend the use of gabapentin for neuropathic pain, but is not recommended for myofascial or other sources of somatic pain. The requesting physician does not address the use of gabapentin in this injured worker who reportedly has knee and low back

pain with no evidence of neuropathic pain. Additionally, the request does not specify the number of tablets prescribed, or the duration of treatment. The request for retro gabapentin 60 mg 1 PO TID is determined to not be medically necessary.

RETRO NORCO 10/325 MG 1 PO Q 6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids section, Weaning of Medications section Page(s): 74-95, 124.

Decision rationale: It is noted that the injured worker has been treated chronically with Norco. The MTUS guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. They do provide guidance on the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy, which is not the case in the current management of this injured worker. The requesting physician does not report on the efficacy of Norco in this injured worker, such as reducing pain and increase functioning with the use of Norco. Additionally, the number of tablets requested or duration of treatment are not addressed. It is not recommended to discontinue opioid treatment abruptly, as weaning of medications is necessary to avoid withdrawal symptoms when opioids have been used chronically. This request however is not for a weaning treatment, but to maintain treatment. The request for retro Norco 10/325 mg 1 PO Q6 is determined to not be medically necessary.