

Case Number:	CM14-0036049		
Date Assigned:	06/23/2014	Date of Injury:	05/02/2005
Decision Date:	11/26/2014	UR Denial Date:	03/12/2014
Priority:	Standard	Application Received:	03/24/2014

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 and 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 55-year-old male who reported an injury on 05/02/2005. The mechanism of injury was not provided within the review. His diagnosis was chronic cervicgia and recurrent myofascial strain diagnoses. Prior treatments were noted to be therapy and medications. The injured worker had a clinical evaluation on 03/03/2014. He was noted to have subjective complaints of severe neck pain related to failed neck syndrome with cervical symptoms, as well as chronic headaches. He reported average pain without medications was 8/10; with medications, 4/10. The physical examination noted tenderness to palpation in the cervical spine. Strength was decreased in the left upper extremity. Sensory was also decreased on the left upper extremity. Deep tendon reflexes in the upper extremities and lower extremities were decreased, but equal. The plan is for renewed medications and physical therapy. The provider's rationale for the request was not provided. A request for authorization form was not found within the documentation submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cambria 50mg, #4: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, Specific Drug List & Adverse Effect Page(s): 71.

Decision rationale: The request for Cambria 50 mg #4 is medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines indicates NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. NSAIDs are recommended by the guidelines for osteoarthritis including knee and hip. The documentation submitted for review does not indicate how long the injured worker has been using the medication and if there has been efficacy with use. This medication was ordered for acute migraine attacks. The guidelines indicate its use for osteoarthritis. In addition, the provider's request fails to provide a dosage frequency. As such, the request for Cambria 50 mg #4 is medically necessary.

Trazodone HCL 100mg #60 with 3 refills: Upheld

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

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

Decision rationale: The request for Trazodone HCL 100mg #60 with 3 refills is not medically necessary. The Official Disability Guidelines state Trazodone is "recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety." The documentation provided for review does not indicate a diagnosis of insomnia. In addition, the provider's request fails to indicate a dosage frequency. As such, the request for Trazodone HCL 100mg #60 with 3 refills is not medically necessary.