MAXIMUS Federal Services

Case Number:	CM14-0138963		
Date Assigned:	09/10/2014	Date of Injury:	08/01/1993
Decision Date:	05/12/2015	UR Denial Date:	08/14/2014
Priority:	Standard	Application Received:	08/27/2014

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, Arizona
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 53-year-old male who reported an injury on 08/01/1993 due to cumulative trauma while performing normal job duties. The injured worker reportedly sustained injuries to multiple body parts. The injured worker's treatment history included surgical intervention, physical therapy, a home exercise program, bracing, and multiple injections. The injured worker's diagnoses included cervical disc disease with facet arthropathy and bilateral upper extremity radiculopathy, thoracic spine sprain/strain, lumbar degenerative disc disease with facet arthropathy and bilateral lower extremity radiculopathy, bilateral peroneal neuropathy, bilateral internal knee derangement, left knee traumatic arthritis, reactionary depression and anxiety, medication induced gastritis, noninsulin dependent diabetes, and bilateral ulnar nerve entrapment. The injured worker was evaluated on 12/03/2014. It was noted that the injured worker had recently had a Toradol injection that did provide pain relief. Objective findings included decreased sensation in the bilateral feet and toes, and decreased reflexes in the bilateral Achilles tendon and bilateral patellar tendon. The injured worker had a positive Tinel's sign bilaterally. The injured worker's treatment plan included continued medications, proper shoes and orthotics, and an additional Toradol injection. No Request for Authorization was submitted to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zanaflex 4mg #60 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxant Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The requested Zanaflex 4mg #60 5 refills is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the use of muscle relaxants be limited to a short duration of treatment. The clinical documentation submitted for review does indicate that the injured worker has been on this medication for several months. Additionally, this, in combination with 5 refills, exceeds guideline recommendations. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. As such, the requested Zanaflex 4mg #60 5 refills is not medically necessary or appropriate. Additionally, the request as it is submitted does not identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined.

Trazodone 150mg #30 5 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Online version-Mental Illness & Stress.

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

Decision rationale: The requested Trazodone 150mg #30 5 refills is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address this request. The Official Disability Guidelines do recommend sedating antidepressants to assist with restoration of sleep patterns secondary to chronic pain. The clinical documentation submitted for review does not adequately assess the injured worker's sleep patterns to support the need for continued use of this medication. Additionally, Official Disability Guidelines only recommend pharmacological intervention for insomnia related to chronic pain for short durations of time. The requested 5 refills would be considered in excess of this recommendation. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. Furthermore, the request as it is submitted does not provide a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Trazodone 150mg #30 5 refills is not medically necessary or appropriate.

Lexapro 10mg #30 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Depressants (SSRIs) Page(s): 107.

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

Decision rationale: The requested Lexapro 10mg #30 5 refills is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does recommend antidepressants in the management of chronic pain. The clinical documentation submitted for review does indicate that the injured worker has been on this medication for an extended duration of time. The guideline recommendations do recommend continued use be based on pain relief and significant functional benefit. The clinical documentation submitted for review does not provide any indication that the injured worker receives any pain relief or functional benefit from the use of this medication. Additionally, 5 refills do not allow for timely reassessment or evaluation. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Lexapro 10mg #30 5 refills is not medically necessary or appropriate.

Xanax 1mg #60 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The requested Xanax 1mg #60 5 refills is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not recommend the long-term use of benzodiazepines in the management of chronic pain, as there is a high risk of physiological and psychological dependence. The clinical documentation submitted for review does indicate that the injured worker has been on this medication for an extended duration of time. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Xanax 1mg #60 5 refills is not medically necessary or appropriate.