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| Case Number: | CM15-0142217 | | |
| Date Assigned: | 08/03/2015 | Date of Injury: | 06/28/2014 |
| Decision Date: | 09/23/2015 | UR Denial Date: | 07/13/2015 |
| Priority: | Standard | Application Received: | 07/22/2015 |

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

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

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 50 year old female, who sustained an industrial injury on June 28, 2014 while working as a bartender-server. The mechanism of injury was a trip and fall in which she landed on her left knee. The injured worker has been treated for left knee, low back and right hip complaints. The diagnoses have included multilevel degenerative disc disease, lumbar facet syndrome, lower back pain, right hip pain, right hip bursitis, lumbar radiculopathy and left knee pain with a history of a medial meniscus tear. The injured worker also had a history of lupus, which was in remission. Treatment and evaluation to date has included medications, radiological studies, MRI, electrodiagnostic studies, left knee injection, physical therapy and a home exercise program. The injured worker has not worked since the day of injury. Current documentation dated June 29, 2015 notes that the injured worker reported increased right hip and left knee pain. The pain was rated a 7 out of 10 the visual analogue scale with medications. The injured worker also noted low back and right hand pain. The low back pain radiated down into the right lower extremity. Associated symptoms included weakness, numbness and tingling. The injured workers sleep quality was noted to be fair. The injured workers activity level had decreased. Examination of the lumbar spine revealed tenderness to palpation and spasm on the right side. Range of motion was restricted with flexion and extension. Lumbar facet loading and a straight leg raise test were positive on the right side. Examination of the right hip revealed tenderness over the groin and trochanter. Range of motion was restricted with internal rotation and external rotation. A FABER (flexion, abduction and external rotation) test was positive. Left knee examination revealed a bony deformity and tenderness to palpation over the medial joint line.

Range of motion was restricted with flexion and extension. Crepitus was noted with active movement. A McMurray's test was positive. The treating physician's plan of care included requests for Trazadone 100 mg # 30 and Lidoderm 5% patches # 30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm 5% patch, QTY: 30.00, 1 patch to skin every day as needed: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): s 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 111-113.

Decision rationale: Regarding the request for Lidoderm, CA MTUS states that topical lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Within the documentation available for review, there is no indication of localized peripheral neuropathic pain despite failure of first-line therapy. Given all of the above, the requested Lidoderm is not medically necessary.

Trazodone 100mg QTY: 30.00, take 1 at bedtime: Upheld

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

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

Decision rationale: Regarding the request for Trazodone, California MTUS guidelines are silent regarding insomnia medication. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there is no current description of the patient's insomnia, no discussion regarding what behavioral treatments have been attempted, and no statement indicating how the patient has responded to the medication. Furthermore, there is no indication that Trazodone is being used for short term use as recommended by guidelines. In the absence of such documentation, the currently requested Trazodone is not medically necessary.