

Case Number:	CM15-0045443		
Date Assigned:	03/17/2015	Date of Injury:	06/25/2007
Decision Date:	04/17/2015	UR Denial Date:	02/12/2015
Priority:	Standard	Application Received:	03/10/2015

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: New York
 Certification(s)/Specialty: Internal Medicine

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 40-year-old female, who sustained an industrial injury on 6/25/2007. The injured worker was diagnosed as having persistent right knee pain, status post multiple arthroscopic procedures, left knee strain, lumbar strain, bilateral shoulder bursitis, right ankle ligament laxity, and depression. Treatment to date has included surgical and conservative measures, including diagnostics, medications, corticosteroid injections, and physical therapy. Currently, the injured worker complains of right knee pain (rated 9/10), low back pain (rated 10/10), right hip pain (rated 10/10), right leg pain with pins and needles sensation (rated 10/10), and aching right ankle pain. Medication use included Norco, Motrin, and Flexaril. Physical exam noted an antalgic gait on the right. Tenderness was noted about the thoracic and lumbar paraspinals. Lumbar range of motion was decreased. Her right knee was tender about the joint line, medially and laterally, and the patellar tendon was tender. No sensory deficits were noted. The treatment plan included a new right knee brace, corticosteroid injection for the right knee, Ambien to decrease symptoms, and Norco for breakthrough pain. Sleep disturbance was not described. A magnetic resonance imaging of the right knee, dated 1/27/2012, showed type 1 myxoid change, posterior horn, medial meniscus.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right knee brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: The Knee.

Decision rationale: According to ODG, a knee brace is indicated if there is evidence of knee instability. There was no evidence of right knee instability documented on physical exam. Evidence-based guidelines necessitate documentation of a diagnosis or a condition such as, knee instability or meniscal cartilage repair. Medical necessity for the requested knee patella brace has not been supported or established. The requested item is not medically necessary.

Ambien 10mg; one by mouth at bedtime, #30 with 2 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 (ODG), Knee and Leg Procedure Summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability guidelines: Insomnia Treatment.

Decision rationale: Ambien (Zolpidem) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia and is rarely recommended for long-term use. It can be habit-forming, may impair function and memory more than opioid analgesics, and may increase pain and depression over the long-term. The treatment of insomnia should be based on the etiology and pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. There is no documentation of duration of prior Ambien use. There is no documentation provided indicating medical necessity for Ambien. The requested medication is not medically necessary.

Norco 10/325mg; one by mouth every 6 hours as needed; #45: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the Treatment of Chronic Pain Page(s): 91-97.

Decision rationale: According to MTUS, Norco is a short-acting opioid analgesic. Opioid drugs are available in various dosage forms and strengths. They are considered the most powerful class of analgesics that may be used to manage both acute and chronic pain. These medications are generally classified according to potency and duration of dosage. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status,

appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. Medical necessity for the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.