

Case Number:	CM15-0053328		
Date Assigned:	03/26/2015	Date of Injury:	11/14/2001
Decision Date:	05/01/2015	UR Denial Date:	02/23/2015
Priority:	Standard	Application Received:	03/20/2015

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: Emergency 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 59 year old female, who sustained an industrial injury on 11/14/2001. The medical records submitted for this review did not include the details regarding the initial injury. Diagnoses include spasms of muscle, pain in joint, lower leg; joint derangement/ meniscus; unspecified myalgia and myositis, and pain in joint, ankle and foot. She is status post multiple surgeries to the back and right knee total knee replacement. Treatments to date include medication therapy, physical therapy, cortisone injections to joints, and epidural injections. Currently, they complained ongoing back pain with increased symptoms to bilateral lower extremities with muscle spasms. On 2/10/15, the physical examination documented complaints of back pain with radiation to lower extremities worse with standing, right greater than left and ongoing knee pain. The physical examination from 1/7/15 documented decreased range of motion in lumbar spine with tenderness, tenderness at bilateral sacroiliac joints. The hips demonstrated tenderness and decreased range of motion and Faber's test positive bilaterally. There was crepitus, effusion and tenderness to bilateral knee. The plan of care included continuation of medication therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zoloft: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain Page(s): 13-15.

Decision rationale: The requested Zoloft is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Antidepressants for Chronic Pain, Pages 13-15, recommend SSRI antidepressants as a second option for the treatment of depression, and even though they are not recommended for the treatment of chronic pain, they are recommended for the treatment of neuropathic pain. "Tricyclic antidepressants are recommended over selective serotonin reuptake inhibitors, unless adverse reactions are a problem." The injured worker has ongoing back pain with increased symptoms to bilateral lower extremities with muscle spasms. The treating physician has documented tenderness and decreased range of motion and Faber's test positive bilaterally. There was crepitus, effusion and tenderness to bilateral knee. The treating physician has not documented failed trials of tricyclic antidepressants, nor objective evidence of derived functional improvement from previous use. The criteria noted above not having been met, Zoloft is not medically necessary.

Zanaflex 4mg, #30: 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 Muscle Relaxants Page(s): 63-66.

Decision rationale: The requested Zanaflex 4mg, #30, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Muscle Relaxants, Page 63-66, do not recommend muscle relaxants as more efficacious than NSAIDs and do not recommend use of muscle relaxants beyond the acute phase of treatment. The injured worker has ongoing back pain with increased symptoms to bilateral lower extremities with muscle spasms. The treating physician has documented tenderness and decreased range of motion and Faber's test positive bilaterally. There was crepitus, effusion and tenderness to bilateral knee. The treating physician has not documented duration of treatment, spasticity or hypertonicity on exam, intolerance to NSAID treatment, nor objective evidence of derived functional improvement from its previous use. The criteria noted above not having been met, Zanaflex 4mg, #30 is not medically necessary.

Percocet 10/325mg, #180: 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 Opioids, On-Going Management, Opioids for Chronic Pain Page(s): 78-82.

Decision rationale: The requested Percocet 10/325mg, #180, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, recommend continued use of this opiate for the treatment of moderate to severe pain, with documented objective evidence of derived functional benefit, as well as documented opiate surveillance measures. The injured worker has ongoing back pain with increased symptoms to bilateral lower extremities with muscle spasms. The treating physician has documented tenderness and decreased range of motion and Faber's test positive bilaterally. There was crepitus, effusion and tenderness to bilateral knee. The treating physician has not documented VAS pain quantification with and without medications, duration of treatment, objective evidence of derived functional benefit such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention, nor measures of opiate surveillance including an executed narcotic pain contract or urine drug screening. The criteria noted above not having been met, Percocet 10/325mg, #180 is not medically necessary.