

Case Number:	CM15-0053571		
Date Assigned:	03/27/2015	Date of Injury:	05/13/2007
Decision Date:	05/01/2015	UR Denial Date:	03/12/2015
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: New York

Certification(s)/Specialty: Internal Medicine, Pulmonary Disease

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 56 year old male, who sustained an industrial injury on 05/13/2007. He has reported injury to the left lower extremity. The diagnoses have included status post left knee arthroscopy, partial medial meniscectomy, and chondroplasty; deep vein thrombophlebitis (DVT) left lower extremity, with progression to complete occlusion of the left popliteal vein and posterior superficial vein. Treatment to date has included medications, diagnostic studies, bracing, acupuncture, physical therapy, and surgical intervention. Medications have included Pradaxa, Ibuprofen, and Ranitidine. A progress note from the treating physician, dated 02/11/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of left knee pain, left lower extremity pain, and low back pain; taking anti-coagulants; and difficulty sleeping. Objective findings included tenderness to palpation of the left calf; and tenderness to palpation of the lumbar spine muscles with guarding. The treatment plan has included prescription medications and request for new interferential unit, as the old one is broken, and it helps a great deal. Request is being made for Prilosec 20 mg #30; replacement of VQ home interferential stimulator unit; and for Ultram ER 150 mg, #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prilosec 20mg #30: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS GI symptoms and Cardiovascular Risk Page(s): 68 - 69.

Decision rationale: The patient is a 56 year old male with an injury on 05/13/2007. He had a left knee injury and had a left knee arthroscopic partial medial meniscectomy and chondroplasty and had a left lower extremity DVT. He has back pain and left lower extremity pain and is taking anticoagulants (Pradaxa) and Ibuprofen. He has a high risk for a GI bleed because he takes NSAIDS and anticoagulants. He meets MTUS criteria for a proton pump inhibitor. Prilosec is medically necessary for this patient.

Replacement of VQ home interferential stimulator unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Inferential Current Stimulation Page(s): 118.

Decision rationale: The patient is a 56 year old male with an injury on 05/13/2007. He had a left knee injury and had a left knee arthroscopic partial medial meniscectomy and chondroplasty and had a left lower extremity DVT. He has back pain and left lower extremity pain and is taking anticoagulants and Ibuprofen. Inferential current stimulation is not a MTUS recommended treatment. MTUS notes that there is no quality evidence of effectiveness. The home inferential unit is not medically necessary.

Ultram ER 150MG, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-Going Management Page(s): 78 - 79.

Decision rationale: The patient is a 56 year old male with an injury on 05/13/2007. He had a left knee injury and had a left knee arthroscopic partial medial meniscectomy and chondroplasty and had a left lower extremity DVT. He has back pain and left lower extremity pain and is taking anticoagulants and Ibuprofen. MTUS, Chronic Pain guidelines criteria for on-going treatment with opiates include documentation of improved functionality with respect to the ability to do activities of daily living or work and monitoring for efficacy, adverse effects and abnormal drug seeking behavior. The documentation provided for review did not meet those criteria and ultram is not medically necessary.