

Case Number:	CM15-0061514		
Date Assigned:	04/07/2015	Date of Injury:	10/10/2011
Decision Date:	05/29/2015	UR Denial Date:	03/16/2015
Priority:	Standard	Application Received:	04/01/2015

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, Washington

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 57 year old female, who sustained an industrial injury on 10/10/11. The mechanism of injury involved heavy lifting. The injured worker was diagnosed as having right knee sprain/ strain, tear of the lateral meniscus of right knee, lumbar sprain/strain, lumbar muscle spasm, lumbar disc disease with radiculopathy, and right hip pain with labral tear. Treatment to date has included medication, diagnostics, and medial branch block. Currently, the injured worker complains of lumbar spine pain and difficulty with sleep due to pain. Per the primary physician's progress report on 02/02/2015, pain was reported as 5/10 in the lumbar spine and 6/10 in the right hip, pain radiating down to the thigh and buttocks. Examination revealed tenderness with palpation over the lumbar paraspinal muscles. Straight leg raise is positive, bilaterally. Patellar compression was positive. Current plan of care included preparation for right knee arthroscopic surgery and continuation of medications for pain relief.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 5/325mg Qty 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. In this case, it is noted that the injured worker has continuously utilized Norco 5/325 mg since at least 10/2014. There is no documentation of objective functional improvement. The injured worker continues to report persistent pain over the lumbar spine and right knee. The injured worker also reported activity limitation and insomnia secondary to chronic pain. There is also no frequency listed in the request. Given the above, the request is not medically necessary at this time.

Protonix 20mg Qty 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton-pump Inhibitors.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: California MTUS Guidelines state, proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. In this case, there was no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. The medical necessity for the requested medication has not been established. Additionally, there is no frequency listed in the request. As such, the request is not medically necessary.

Soma 350mg Qty 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: The California MTUS Guidelines state muscle relaxants are recommended as nonsedating second line options for short term treatment of acute exacerbations. Soma should not be used for longer than 2 to 3 weeks. There was no documentation of palpable muscle spasm or spasticity upon examination. It is also noted, the injured worker has utilized the above medication since at least 10/2014. Guidelines would not support long term use of this medication. There is also no frequency listed in the request. As such, the request is not medically necessary.

Trazodone 50mg Qty 30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress Chapter, Trazodone.

Decision rationale: The Official Disability Guidelines recommend trazodone as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms. In this case, the injured worker does not maintain a diagnosis of insomnia, depression or anxiety. In addition, it is noted that the injured worker has continuously utilized the above medication since at least 10/2014. The injured worker continues to report difficulty falling asleep. The medical necessity for the ongoing use of this medication has not been established in this case. There is also no frequency listed in the request. Given the above, the request is not medically necessary.