

Case Number:	CM15-0092958		
Date Assigned:	05/19/2015	Date of Injury:	02/17/2011
Decision Date:	07/03/2015	UR Denial Date:	04/21/2015
Priority:	Standard	Application Received:	05/14/2015

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

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 65 year old male, who sustained an industrial injury on 2/17/2011. The mechanism of injury is unknown. The injured worker was diagnosed as having lumbar sprain/strain, cervical sprain/strain, right knee sprain/strain, status post left above the knee amputation (after staph infection following total knee replacement) and status post right leg fracture. There is no record of a recent diagnostic study. Treatment to date has included surgery, therapy and medication management. In a progress note dated 3/19/2015, the injured worker complains of pain in the neck, low back and right knee. The treating physician is requesting Zoloft 50 mg #30 with 4 refills, Soma 350 mg #120 with 4 refills, 1 home assessment and transportation to medical appointments.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zoloft 50mg quantity 30 with 4 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, Mental Illness and Stress: Sertraline (Zoloft).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Medications for chronic pain Page(s): 13-16, 60.

Decision rationale: According to the 03/19/2015 report, this patient presents with a constant 8/10 neck pain, constant 10/10 low back pain, constant 8-9/10 right knee pain. The patient also complains of anxiety and depression due to pain or loss of work. The current request is for Zoloft 50mg quantity 30 with 4 refills. The request for authorization is not included in the file for review. The patient's work status is temporary total disability until 04/30/2015. The MTUS pages 13-16 states, "Selective serotonin reuptake inhibitors (SSRIs), a class of antidepressants that inhibit serotonin reuptake without action on noradrenaline, are controversial based on controlled trials. (Finnerup, 2005) (Saarto-Cochrane, 2005) It has been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain. (Namaka, 2004) More information is needed regarding the role of SSRIs and pain." Review of the provided reports show Zoloft was first mentioned in the 08/21/2014 report; it is unknown exactly when the patient initially started taking this medication. In this case, the patient is prescribed Zoloft for probably for anxiety and depression. However, there was no discussion of the efficacy of the medication. MTUS page 60 require that medication efficacy in terms of pain reduction and functional gains must be discussed when used. The medical necessity cannot be substantiated at this time; therefore, this request is not medically necessary.

1 Home Assessment: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services. Decision based on Non-MTUS Citation Official Disability Guidelines, Home Health Services.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

Decision rationale: According to the 03/19/2015 report, this patient presents with a constant 8/10 neck pain, constant 10/10 low back pain, and constant 8-9/10 right knee pain. The current request is for 1 Home Assessment to address home health aid. The request for authorization is not included in the file for review. The patient's work status is temporary total disability until 04/30/2015. Regarding home health service, MTUS guidelines recommend medical treatment for patients who are home bound, on a part-time or intermittent basis, generally up to no more than 35 hours per week. MTUS guidelines typically do not consider homemaking services such as shopping, cleaning, laundry, and personal care, medical treatments if these are the only services needed. Review of the provided reports show no documentation of why the patient is unable to perform self-care. The patient is not home bound. No neurologic and physical deficits are documented on examination. However, the patient is status post amputation of mid thigh left. In this case, given the patient above knee amputation, a home evaluation appears quite reasonable. A home visiting nurse maybe required to get this information for the needs of self-care due to the loss of function of the lower limb and mobility. The requested home assessment maybe indicated. Therefore, this request is medically necessary.

Soma 350mg quantity 120 with four refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma).

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

Decision rationale: According to the 03/19/2015 report, this patient presents with a constant 8/10 neck pain, constant 10/10 low back pain, and constant 8-9/10 right knee pain. The current request is for Soma 350mg quantity 120 with four refills. The request for authorization is not included in the file for review. The patient's work status is temporary total disability until 04/30/2015. For muscle relaxants for pain, the MTUS Guidelines page 63 state Recommended non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbation in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension and increasing mobility; however, in most LBP cases, they showed no benefit beyond NSAIDs and pain and overall improvement. A short course of muscle relaxant may be warranted for patient's reduction of pain and muscle spasms. Review of the available records indicates that this patient has been prescribed this medication longer then the recommended 2-3 weeks. The treating physician is requesting Soma #120 and this medication was first noted in the 08/21/2014 report. Soma is not recommended for long-term use. The treater does not mention that this is for a short-term use to address a flare-up or an exacerbation. Therefore, the current request is not medically necessary.

Transportation to all medical appointments: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Knee and leg chapter, transportation.

Decision rationale: According to the 03/19/2015 report, this patient presents with a constant 8/10 neck pain, constant 10/10 low back pain, and constant 8-9/10 right knee pain. The current request is for Transportation to all medical appointments because patient is wheelchair bounded. The request for authorization is not included in the file for review. The patient's work status is temporary total disability until 04/30/2015. ODG guidelines Knee chapter under transportation states, "Recommended for medically-necessary transportation to appointments in the same community for patients with disabilities preventing them from self-transport." In this patient, the patient present with LEFT leg above knee amputation. The treater does not discuss whether or not the patient is able to self-ambulate with a prosthesis. There is no discussion as to why the patient is unable to drive given the intact right leg. No discussion is provided regarding social support as well. The treater does not define the patient's transportation needs very well. The request is not medically necessary.