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| Case Number: | CM13-0018547 | | |
| Date Assigned: | 10/11/2013 | Date of Injury: | 07/04/2010 |
| Decision Date: | 04/30/2014 | UR Denial Date: | 07/30/2013 |
| Priority: | Standard | Application Received: | 08/29/2013 |

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a patient has a date of injury of July 4, 2010. A utilization review determination dated July 30, 2013, recommends the non-certification of Prilosec, Flexeril, and trazodone. A progress report dated August 16, 2013, includes subjective complaints of lower back pain with numbness in the left leg, which has decreased since surgery. The patient is interested in having a fusion surgery. The physical examination identifies normal sensation and motor strength. The diagnoses include ruptured L4-L5 disc, sleep disruption, symptoms of depression, left L5 nerve root impingement per an electromyography/nerve conduction velocity (EMG/NCV), and status post microdiscectomy L4-L5. The treatment plan recommends an independent medical review regarding L4-5 fusion, and continuing medications. The medications include Lidoderm patch, Norco, OxyContin, trazodone for sleep, Fexmid, and Prilosec. A progress report dated July 5, 2013 indicates that Flexeril is being prescribed for muscle spasms, Prilosec is being prescribed to reduce gastric side effects from medications, and trazodone is being prescribed for sleep.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRILOSEC 20MG, #60 DAILY: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), PAIN CHAPTER, PROTON PUMP INHIBITORS (PPIs).

Decision rationale: The Chronic Pain Guidelines indicate that proton pump inhibitors (PPIs) are appropriate for the treatment of dyspepsia secondary to non-steroidal anti-inflammatory drug (NSAID) therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. In light of the above issues, the currently requested omeprazole is not medically necessary.

FLEXERIL 7.5MG #60 TWICE A DAY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64.

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

Decision rationale: The Chronic Pain Guidelines support the use of non-sedating muscle relaxants to be used with caution as a second line option for the short-term treatment of acute exacerbations of pain. The Guidelines go on to state that cyclobenzaprine specifically is recommended for a short course of therapy. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the cyclobenzaprine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by the guidelines. In the absence of such documentation, the currently requested Flexeril is not medically necessary.

TRAZODONE 50MG #30 AT BEDTIME: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG PAIN (UPDATED 06/07/13), INSOMNIA TREATMENT, and the [HTTP://WWW.WHEELSONLINE.COM/ORTHO/TRAZODONE_DESYREL](http://www.wheelsonline.com/ortho/trazodone_desyrel).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), CHRONIC PAIN, SLEEP MEDICATION, INSOMNIA TREATMENT.

Decision rationale: The Official Disability Guidelines recommend the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state that the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. It is recommended that treatments for insomnia should reduce time to sleep onset, improve sleep maintenance, avoid residual effects and increase next-day functioning. Within the documentation available for review, there are no

subjective complaints of insomnia, no discussion regarding how frequently the insomnia complaints occur or how long they have been occurring. There is no statement indicating what behavioral treatments have been attempted for the condition of insomnia, and no statement indicating how the patient has responded to trazodone treatment. In the absence of such documentation, the currently requested trazodone is not medically necessary.