

Case Number:	CM14-0107277		
Date Assigned:	08/01/2014	Date of Injury:	07/12/2011
Decision Date:	09/26/2014	UR Denial Date:	06/25/2014
Priority:	Standard	Application Received:	07/10/2014

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 Emergency Medicine, and is licensed to practice in New York. 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:

The patient is a year-old male who was injured on July 12, 2011. The patient continued to experience low back pain with radiation to the right lower extremity. Physical examination was notable for fairly good strength bilaterally. Diagnoses included failed back surgery syndrome and lumbar disc disease. Treatment included medications, physical therapy, surgery, and H wave therapy. Requests for authorization for Norco 10/325 mg #240 and Trazodone 50-100 mg #120 were submitted for consideration.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Norco 10/325 mg # 240, date of service 5/29/2014: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Pain Interventions and Guidelines Page(s): 74-96.

Decision rationale: Norco is the compounded medication containing hydrocodone and acetaminophen. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the

patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain of function. It is recommended for short term use if first-line options, such as acetaminophen or NSAIDS have failed. Opioids may be a safer choice for patients with cardiac and renal disease than antidepressants or anticonvulsants. Acetaminophen is recommended for treatment of chronic pain & acute exacerbations of chronic pain. Acetaminophen overdose is a well-known cause of acute liver failure. Hepatotoxicity from therapeutic doses is unusual. Renal insufficiency occurs in 1 to 2% of patients with overdose. The recommended dose for mild to moderate pain is 650 to 1000 mg orally every 4 hours with a maximum of 4 g/day. In this case the patient had been taking the Norco since at least October 2013 and had not obtained analgesia. There is no documentation that the patient has signed an opioid contract or is participating in urine drug testing. Criteria for long-term opioid use have not been met. Therefore, this request is not medically necessary.

Rerospective Trazadone 50-100 mg # 120, date of service 5/29/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Anti-depressants.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain: Insomnia treatment.

Decision rationale: Trazodone is a tetracyclic antidepressant usually prescribed for insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. Insomnia treatment should be based on etiology. Most medications have only been evaluated for short term use (less than 4 weeks). Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Sedating antidepressants are often used to treat insomnia; however, there is less evidence to support their use for insomnia. They may be an option in patients with coexisting depression. Trazodone is one of the most commonly prescribed agents for insomnia. Side effects of this drug include nausea, dry mouth, constipation, drowsiness, and headache. Negative next-day effects such as ease of awakening may offset improvements in sleep onset. Tolerance may develop and rebound insomnia has been found after discontinuation. The patient has been taking this medication since at least October 2013. Increased duration of treatment increases the risk of tolerance and other adverse effects. Therefore, this request is not medically necessary.