

Case Number:	CM14-0031024		
Date Assigned:	06/20/2014	Date of Injury:	03/25/2013
Decision Date:	07/22/2014	UR Denial Date:	02/12/2014
Priority:	Standard	Application Received:	03/12/2014

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 Physical Medicine and Rehabilitation, 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:

The injured worker is a 40-year-old male with a reported date of injury on 03/25/2013. The injury reportedly occurred due to a slip and twist to his back. His diagnoses were noted to include lumbar degenerative disc disease at L3-4 and L4-5, lumbar radiculopathy at L3-4 and L4-5 with L4 and L5 nerve root impingement, facet osteoarthritis at L5-S1, spinal stenosis at L3-4 and L4-5, and cervical sprain/strain. His previous treatments were noted to include medications, lumbar epidural steroid injections, exercise, stretching, ergonomic positioning, ice, and heat. The provider reported the injured worker received a lumbar epidural steroid injection 08/01/2013 and had continued to have some relief to the low back pain but still had significant right lower extremity pain. The progress report dated 01/15/2014 reported the injured worker complained of pain to his neck and shoulders. The injured worker reported his pain was 5/10 to 7/10, described as sharp, stabbing, and a numbing sensation. The injured worker also reported a lesser complaint of the posterior neck and shoulder area. The injured worker reported he was using medication with benefit and no side effects. The physical examination reported tightness and tenderness of the posterior cervical region with 30% restriction in both extension and flexion. The physical examination of the lumbar spine reported tightness and tenderness over the right greater than left lumbosacral area, over the paraspinal musculatures of the phasic and postural groups. There was a 50% restriction of lumbar flexion and extension as well as a positive straight leg raise noted. His medications were noted to include Percocet 10/325 (one 3 times a day), Neurontin 300 mg (two 3 times a day), Flexeril 10 mg (3 times a day), ibuprofen 800 mg (4 times a day), MS-Contin 15 mg, trazodone 50 mg, and Prilosec 20 mg. The request is for MS-Contin ER 15 mg #60, Percocet 325/10 mg #90, and trazodone hydrochloride 50 mg #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

MS Contin ER 15mg, #60: Upheld

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

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

Decision rationale: The request for MS-Contin ER 15 mg #60 is not medically necessary. The injured worker has been taking this medication since at least 10/2013. According to the California Chronic Pain Medical Treatment Guidelines, the ongoing use of opioid medications may be supported with detailed documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines also state the 4A's for ongoing monitoring; including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors should be addressed. There is a lack of documentation regarding evidence of decreased pain on a numerical scale, improved functional status, and it is unclear as to whether or not the injured worker has had consistent urine drug screens and when the last test was performed. Therefore, due to the lack of evidence regarding significant pain relief, increased function, and without details regarding the urine drug testing to verify appropriate medication use and the absence of aberrant behavior, the ongoing use of opioid medications is not supported by the guidelines. Additionally, the request failed to provide the frequency at which this medication is to be utilized. As such, the request is not medically necessary.

Percocet 325/10mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percocet -short acting Opioid.

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

Decision rationale: The request for Percocet 325/10 mg #90 is not medically necessary. The injured worker has been taking this medication since 09/2013. According to California Chronic Pain Medical Treatment Guidelines, the ongoing use of opioid medications may be supported with detailed documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines also state the 4A's for ongoing monitoring; including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors should be addressed. There is a lack of documentation regarding evidence of decreased pain on a numerical scale, improved functional status, and it is unclear as to whether or not the injured worker has had consistent urine drug screens and when the last test was performed. Therefore, due to the lack of evidence regarding significant pain relief, increased function, and without details regarding the urine drug testing to verify appropriate medication use and the absence of aberrant behavior, the ongoing use of opioid medications is not supported by the guidelines. Additionally,

the request failed to provide the frequency at which this medication is to be utilized. As such, the requested service is not medically necessary.

Trazodone Hydrochloride 50mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trazodone Hydrochloride- antidepressant.

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 and Stress, Trazodone (Desyrel).

Decision rationale: The request for trazodone hydrochloride 50 mg #30 is not medically necessary. The injured worker has been taking this medication since at least 09/2013. The Official Disability Guidelines recommend trazodone as an option for insomnia, only for injured workers with potentially coexisting mild psychiatric symptoms such as depression or anxiety. The guidelines state evidence for the off-label use of trazodone for the treatment of insomnia is weak. The current recommendation is to utilize a combined pharmacological and psychological and behavioral treatment when primary insomnia is diagnosed. Also, it was noted, there has been no dose finding study performed to assess the dose of trazodone for insomnia in non-depressed patients. The documentation provided indicated the injured worker has been having trouble sleeping due to pain. However, the guidelines do not recommend trazodone for insomnia unless the injured worker has potentially coexisting mild psychiatric symptoms such as depression or anxiety. Depression or anxiety was not noted within the documentation provided, and therefore, trazodone is not warranted at this time. Additionally, the request failed to provide a frequency at which this medication is to be utilized. As such, the request is not medically necessary.