

Case Number:	CM14-0082078		
Date Assigned:	08/01/2014	Date of Injury:	03/17/2010
Decision Date:	09/18/2014	UR Denial Date:	05/16/2014
Priority:	Standard	Application Received:	06/02/2014

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 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:

The injured worker is a 45-year-old male who sustained an injury on March 12, 2010. He was diagnosed with (a) displacement, lumbar disc without myelopathy; (b) degenerated disc disease, lumbar; (c) stenosis, lumbar spine; (d) lumbar radiculopathy; and (e) facet arthropathy, lumbar. He was seen on May 1, 2014 for an evaluation. He had complaints of mid and low back pain, which continued to affect his activities of daily living. He reported that his average pain without medications was 8-10/10. With medications, the pain was 2/10. The medications prescribed were keeping the injured worker functional, allowing for increased mobility and tolerance of activities of daily living and home exercises. Examination of the lumbar spine revealed tenderness over the L5-S1. Tenderness was also present over the paraspinals with multiple level disc protrusions. Injection sites were well healed with no signs of infection. Range of motion was limited. Straight leg raising test was positive bilaterally. Diminished strength was noted over the bilateral lower extremities. Lyrica was prescribed. Trazodone was prescribed for sleep while Tramadol was prescribed for mild to moderate pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazodone HCL 50mg Tabs #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Treatment for Worker's Compensation, Online Edition. Chapter: Pain, Insomnia treatment.

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: The request for trazodone hydrochloride 50 mg #60 is not medically necessary at this time. Medical records revealed that this medication was dispensed for treatment of insomnia. However, there was no documentation of complaints that the injured worker has sleep difficulties. More so, the Official Disability Guidelines also stated that there is less evidence to establish the use of trazodone for insomnia. With these, the request for trazodone hydrochloride 50 mg #60 is not necessary at this time.

Tramadol Hcl 50mg Tab #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list: Tramadol (Ultram).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-80.

Decision rationale: The request for tramadol hydrochloride 50 mg #180 is not medically necessary at this time. From the medical records reviewed, while there was subjective report of favorable response to medications, there was no indication of contraindications for use of first-line medications for pain or whether the injured worker failed a trial of non-opioid analgesics. Hence, proceeding with prescription of this medication is not in accordance with the guidelines and is, therefore, not necessary.

Lyrica 100mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Pregabalin (Lyrica) Specific Anti-Epilepsy Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pregabalin (Lyrica) Page(s): 99.

Decision rationale: The request for Lyrica 100 mg #60 is not medically necessary at this time. According to the California Medical Treatment Utilization Schedule, this medication is primarily indicated for diabetic neuropathy, postherpetic neuralgia, and fibromyalgia. There was no mention in the medical records reviewed why this medication was prescribed. More so, the injured worker is not diagnosed with diabetic neuropathy, postherpetic neuralgia, or fibromyalgia to warrant the use of this medication. Hence, Lyrica 100 mg #60 is not medically necessary at this time.