MAXIMUS Federal Services

Case Number:	CM14-0193150		
Date Assigned:	11/20/2014	Date of Injury:	06/05/2003
Decision Date:	01/14/2015	UR Denial Date:	11/04/2014
Priority:	Standard	Application Received:	11/19/2014

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:

This 52-year-old female reportedly sustained a work related injury on June 5, 2003 of undisclosed cause. Diagnoses include arthroscopy left knee, renal failure, hypertension; open reduction and internal fixation (ORIF) left hip, arthritis, chronic pain syndrome, back pain, degenerative disc disease (DDD) spine, insomnia, depression, and anxiety. Pain management visit dated May 23, 2014 noted magnetic resonance imaging (MRI) with impression of multi level degenerative changes and mild to moderate central canal narrowing with possible disc protrusion. Pain is listed as 4-8/10 and averages 5/10 to legs, buttocks, thoracic spine and low back. Pain is worse in the morning and afternoon and she rests or reclines 25 to 50% of the time while awake. Pain management visit dated October 20, 2014 is unchanged from previous visit on September 17, 2014 and noted massage therapy weekly "increased her function by doing light yard work, standing longer, improving posture and decreased pain/tension". Pain is rated 4-7/10 and located in legs, neck, buttocks, thoracic spine and low back. It is described as aching, cramping and dull. She uses a cane or walker for ambulation. Current medications are Valium 5mg, Percocet 10/325mg, Voltaren 1% gel, Trazodone HCL 100mg, Gabapentin 300mg, Metoprolol Succinate 200mg, Metolazone 5mg, Humalog, Lantus, Aspirin 81mg TBEC and Colace 100mg. On November 4, 2014 Utilization Review determined a request dated October 28, 2014 for 30 tablets of Trazodone HCL 100mg, 120 tablets of Percocet 10/325mg, 30 tablets of Valium 5mg and 3 tubes of Voltaren 1% Gel is non certified. Medical Treatment Utilization Schedule (MTUS) guidelines were used in the determination. Application for independent medical review is dated November 15, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

30 tablets of Trazodone HCL 100 mg: Overturned

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 (ODG) ,Mental and Stress, Trazodone (Desyrel)

Decision rationale: The patient presents with chronic leg, buttocks, thoracic spine and low back pain rated 5/10 on average. The current request is for 30 tablets of Trazodone HCL 100mg. The patient has been on the medication since at least 5/23/14 (80). The treating physician report dated 10/20/14 (50) states the medication is for "insomnia and depression." MTUS and ACOEM are silent on this medication. ODG states the following on Trazodone (Desyrel): "Recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. See also Insomnia treatment, where it says there is limited evidence to support its use for insomnia, but it may be an option in patients with coexisting depression.The provider does state the medication is for sleep. The report provided does discuss the patient's sleep assessment. However, patient's response to its prior use was not discussed in terms of number of hours sleep afforded and specific improvements in next-day functioning or ADL's. The progress note states the IW feels depressed, however, the review of systems say the IW denies depression. Current working diagnoses include insomnia and depression. The use of Trazodone for insomnia with depression is within guidelines; therefore, recommendation is for medically necessary.

120 tablets of Percocet 10/325 mg: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Page(s): 88-89.

Decision rationale: The patient presents with chronic leg, buttocks, thoracic spine and low back pain rated 5/10 on average. The current request is for 120 tablets of Percocet 10/325 mg. Per the reports provided, it is known the patient has been taking this medication since at least 5/23/14 (pg. 80). MTUS Guidelines require functioning documentation using a numerical scale or validated instrument at least one every six months, documentation of the 4A's (analgesia, ADLs, adverse side effect, adverse behavior) is required. Furthermore, under outcome measure, it also recommends documentation of chronic pain, average pain, least pain, the time it takes for medication to work, duration of pain relief with medication etc. The treating physician has documented pain scales with opioid usage and states that the patient's pain is rated a 7/10 without medication and a 4/10 with medication. There is an activity assessment that states, "The patient uses a cane, the patient is up and out of bed daily and the patient is not out of the house daily."

There functional benefit from medication is listed under "patient activity." The treating physician discusses side effects under the "review of systems." There a copy of urine drug screening results. The MTUS guidelines have specific reporting requirements for ongoing opioid usage found in the medical records provided. Recommendation is for medically necessary.

30 Tablets of Valium mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Specific Antidepressants Page(s): 24.

Decision rationale: The patient presents with chronic leg, buttocks, thoracic spine and low back pain rated 5/10 on average. The current request is for 30 Tablets of Valium mg. Review of the reports submitted indicate that the patient has been taking Valium since at least 5/23/14 The MTUS guidelines state that Benzodiazepines are "Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks." The prescription specifies daily usage. The patient has been utilizing Valium for at least 5 months, which is not supported by MTUS. Recommendation is for not medically necessary.

Tubes of Voltaren 1% Gel: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 111.

Decision rationale: The patient presents with chronic leg, buttocks, thoracic spine and low back pain rated 5/10 on average. The provider requests for: Tubes of Voltaren 1% Gel. The reports provided indicate that the patient has been taking this medication since at least 5/23/14 (80). MTUS guidelines state that topical NSAIDs are recommended for short-term use (4 to 12 weeks). MTUS additionally states the following regarding topical analgesics: 'largely experimental in use with few randomized controlled trials to determine efficacy or safety." "There is little to no research to support the use of many of these agents." The provider does not provide any discussion regarding the efficacy and use of this topical product. Topical NSAIDs are indicated for peripheral joint arthritis/tendinitis and there is no diagnosis of this. Recommendation is for not medically necessary.