

Case Number:	CM15-0002750		
Date Assigned:	01/13/2015	Date of Injury:	06/23/2006
Decision Date:	03/23/2015	UR Denial Date:	12/10/2014
Priority:	Standard	Application Received:	01/06/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 58-year-old male who reported an injury on 06/23/2006. The mechanism of injury was not specifically stated. The current diagnoses include lumbar disc disorder, lumbar radiculopathy, lumbar postlaminectomy syndrome, low back pain, and chronic pain syndrome. The injured worker presented on 11/24/2014 with complaints of 5/10 pain. The injured worker reported ongoing low back and right leg pain with numbness and tingling. The current medication regimen includes trazodone 50 mg, Voltaren 1% gel, tramadol HCl 50 mg, omeprazole 20 mg, and Carafate 1 gm. Upon examination of the lumbar spine, there was hypertonicity, spasm, tenderness, tight muscle band, and trigger points. The recommendations included continuation of the current medication regimen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazodone 50mg, 1 tid #90, 1 refill: Upheld

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 Illness & Stress Chapter, Trazodone (Desyrel).

Decision rationale: The Official Disability Guidelines recommend trazodone as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. The injured worker does not maintain a diagnosis of depression or anxiety. The injured worker does not maintain a diagnosis of insomnia or sleep disorder. The medical necessity for the requested medication has not been established in this case. As such, the request is not medically appropriate.

Tramadol HCL 50mg 1 tid prn pain #90, 1 refill: Upheld

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 Page(s): 74-82.

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. It is unclear how long the injured worker has utilized tramadol HCl 50 mg. There is no documentation of objective functional improvement. Previous urine toxicology reports documenting evidence of patient compliance and nonaberrant behavior were not provided. Given the above, the request is not medically appropriate in this case.