

Case Number:	CM15-0162412		
Date Assigned:	09/04/2015	Date of Injury:	07/11/2006
Decision Date:	10/06/2015	UR Denial Date:	08/11/2015
Priority:	Standard	Application Received:	08/18/2015

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: Family Practice

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 43 year old female, who sustained an industrial injury on 7-11-2006. She reported low back pain. Diagnoses have included chronic, intractable low back pain secondary to lumbosacral degenerative disc disease, status post lumbar fusion 5-9-2013, chronic pain syndrome, opioid dependence, anxiety and depression. Treatment to date has included physical therapy, magnetic resonance imaging (MRI), surgery and medication. According to the progress report dated 7-29-2015, the injured worker complained of chronic low back pain. With medications, she was able to take care of her dog and home with her husband's help. Objective findings revealed a mildly antalgic, steady gait. There was tenderness to palpation of her lumbar paraspinals. Authorization was requested for Percocet and Trazadone.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/335mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids; Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC]; Opioids, criteria for use, Therapeutic Trial of Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78, 80.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the long-term use of opioids, including Percocet. These guidelines have established criteria on the use of opioids for the ongoing management of pain. Actions should include: prescriptions from a single practitioner and from a single pharmacy. The lowest possible dose should be prescribed to improve pain and function. There should be an ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. Pain assessment should include: current pain, the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. There should be evidence of documentation of the "4 As for Ongoing Monitoring." These four domains include: pain relief, side effects, physical and psychological functioning, and the occurrence of any potentially aberrant drug-related behaviors. Further, there should be consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain that does not improve on opioids in 3 months. There should be consideration of an addiction medicine consult if there is evidence of substance misuse (Pages 76-78). Finally, the guidelines indicate that for chronic pain, the long-term efficacy of opioids is unclear. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy (Page 80). Based on the review of the medical records, there is insufficient documentation in support of these stated MTUS/Chronic Pain Medical Treatment Guidelines for the ongoing use of opioids. There is insufficient documentation of the "4 As for Ongoing Monitoring." The treatment course of opioids in this patient has extended well beyond the timeframe required for a reassessment of therapy. In summary, there is insufficient documentation to support the chronic use of an opioid in this patient. Treatment with Percocet 10/325mg # 60 is not considered as medically necessary.

Trazodone 150mg, #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), Pain Chapter, 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) Chapter: Pain Section: Insomnia Treatment.

Decision rationale: The records indicate that this patient is using the antidepressant for the treatment of insomnia. The Official Disability Guidelines comment on the use of pharmacologic agents for the treatment of insomnia. These guidelines recommend that treatment be based on the etiology. 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. The specific component of insomnia should be addressed: (a) Sleep onset; (b) Sleep maintenance; (c) Sleep quality; & (d) Next-day functioning. In this

case, there is insufficient documentation to support the use of trazodone as a treatment for insomnia. There is insufficient evidence that the patient has undergone an evaluation for the cause of insomnia. Further, there is insufficient documentation on the specific component of insomnia that is being addressed; as indicated above. Finally, there is insufficient documentation that the current use of trazodone has resulted in significant improvement in the patient's problem with insomnia. For these reasons, trazodone 150mg #60 is not medically necessary.