

Case Number:	CM15-0163716		
Date Assigned:	08/31/2015	Date of Injury:	10/15/1999
Decision Date:	09/30/2015	UR Denial Date:	08/14/2015
Priority:	Standard	Application Received:	08/20/2015

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: Emergency Medicine

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 69 year old female who sustained an industrial injury on 10-15-1999. The injured worker was diagnosed with low back pain, lumbar intervertebral disc displacement, lumbar facet arthropathy, lumbosacral radiculopathy, cervicgia, cervical facet arthropathy, sacroiliac joint arthropathy, depressive disorder, anxiety and insomnia. The injured worker is status post L5-S1 laminectomy (no date documented). Past therapies and treatments were not discussed. According to the primary treating physician's progress report on July 8, 2015, the injured worker continues to experience chronic l back and right wrist pain. Examination noted diffuse tenderness over the entire spine and neck. There was noted deformity of the right wrist and hand. There was no edema of the extremities. Current medications were listed as Norco 10mg-325mg, Gabapentin, Paroxetine and Trazodone. Treatment plan consists of continuing medications as prescribed, continuing to stay active as much as possible and the current request for Norco 10mg-325mg, Paroxetine and Trazodone.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg, #150 with 6 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-79.

Decision rationale: Norco is acetaminophen and hydrocodone, an opioid. Patient has chronically been on an opioid pain medication. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. Documentation fails criteria. Provider notes that patient has continued severe pain. There is no documentation of objective improvement in pain or function, only subjective claims. There is no documentation of screening for abuse or side effects noted. There is no long-term plan documented. This prescription is invalid. Norco is a schedule-2 controlled medication, refills are not allowed. This request would give the patient almost 7months of unmonitored opioid use. It is inappropriate and not medically necessary.

Trazodone 100mg, #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental Illness & Stress 2015 Insomnia treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic pain Page(s): 13-16.

Decision rationale: Trazodone is a SARI (serotonin antagonist and re-uptake inhibitor) antidepressant. As per MTUS Chronic pain guideline, antidepressants for chronic and neuropathic pain may be considered. Documentation states that it may be prescribed for insomnia. As per guidelines, Trazodone may be used for depression and insomnia. However, the provider has failed to document objective benefit with this medication. There is no documentation concerning claimed depression or insomnia. Trazodone is not medically necessary.

Paroxetine 10mg, #90 with 3 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic) Paxil and SSRIs (selective serotonin reuptake inhibitors).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic pain Page(s): 13-16.

Decision rationale: Prozac is fluoxetine, an SSRI (selective serotonin reuptake inhibitor) antidepressant. As per MTUS Chronic pain guideline, antidepressants for chronic and neuropathic pain may be considered. Tricyclic antidepressants are considered 1st line and SNRIs are considered 2nd line. SSRIs are considered 3rd line and has poor evidence to show efficacy in chronic pain or neuropathic pain. It has been shown to have no effect in low back

pain. MTUS guideline requires documentation of treatment efficacy, which includes evaluation of function, changes in analgesic use, sleep and psychological assessment. The provider has failed to document anything to support use of Prozac. Patient may be taking this for depression but provider has failed to document anything related to claimed depression, improvement on medications or any notes concerning assessment or treatment by a psychiatrist or psychologist. There is no appropriate documentation as to why a 3rd line medication is being used and there is no appropriate documentation of efficacy. The number of refills is not appropriate. Prozac is not medically necessary.