

Case Number:	CM15-0165193		
Date Assigned:	09/02/2015	Date of Injury:	05/23/2012
Decision Date:	10/06/2015	UR Denial Date:	08/14/2015
Priority:	Standard	Application Received:	08/24/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 29 year old female, who sustained an industrial injury on 5-23-12. The diagnoses have included lumbar sprain, thoracic or lumbosacral neuritis or radiculitis, displacement of intervertebral disc lumbar, other post-surgical status, status post lumbar spine surgery and status post left laminectomy. Treatment to date has included medications, activity modifications, diagnostics, surgery, physical therapy, acupuncture, transcutaneous electrical nerve stimulation (TENS), H-wave unit, home exercise program (HEP), and other modalities. Currently, as per the physician progress note dated 7-29-15, the injured worker complains of pain in the left side hip and back. The diagnostic testing that was performed included Magnetic Resonance Imaging (MRI) of the lumbar spine. The current medications included Percocet, Celexa, Trazadone and Neurontin. The objective findings-physical exam reveals that the injured worker has antalgic gait and heel and toe ambulation could not be completed due to pain. There is stiffness, tightness and pain noted at L4-L5 as well as bilateral posterior, superior iliac spine. The lumbar range of motion is restricted in flexion, extension as well as side to side tilt. Work status is totally temporary disabled until 8-26-15. The physician requested treatments included Trazodone 50mg #30, Celexa 40mg #30 and Percocet 10-325mg #120.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazodone 50mg 1 tab po qhs #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use/Opioids, specific drug list.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Mental Illness & Stress, Insomnia (2) Mental Illness & Stress, Insomnia treatment.

Decision rationale: The claimant sustained a work injury in May 2012 and continues to be treated for low back pain. She underwent a lumbar discectomy in February 2014. In June 2015, medications are referenced as decreasing pain from 8-9/10 only down to 7/10. On 07/29/15, she had completed physical therapy and acupuncture treatments. She was having worsening pain. She was not receiving medications. Physical examination findings included an antalgic gait. There was lumbar spine and bilateral posterior superior iliac spine stiffness, tightness, and pain. There was decreased left lower extremity strength and sensation. Medications were prescribed. Celexa was being prescribed for depression and trazodone was being prescribed for insomnia. Ambien had previously been prescribed on a long-term basis. The treatment of insomnia should be based on the etiology and pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. In this case, the nature of the claimant's sleep disorder is not provided. Whether the claimant has primary or secondary insomnia has not been determined. Conditions such as medication or stimulant side effects, depression, anxiety, restless legs syndrome, obstructive sleep apnea, pain and cardiac and pulmonary conditions, if present, should be identified and could be treated directly. The requested Trazodone was not medically necessary.

Celexa 40mg 1 tab po qd #30: 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, Anti-depressants.

Decision rationale: The claimant sustained a work injury in May 2012 and continues to be treated for low back pain. She underwent a lumbar discectomy in February 2014. In June 2015, medications are referenced as decreasing pain from 8-9/10 only down to 7/10. On 07/29/15, she had completed physical therapy and acupuncture treatments. She was having worsening pain. She was not receiving medications. Physical examination findings included an antalgic gait. There was lumbar spine and bilateral posterior superior iliac spine stiffness, tightness, and pain. There was decreased left lower extremity strength and sensation. Medications were prescribed. Celexa was being prescribed for depression and trazodone was being prescribed for insomnia. Ambien had previously been prescribed on a long-term basis. Antidepressant medication is recommended for the treatment of depression. However, there is no evidence

that this claimant has a diagnosis of depression. Celexa is being specifically prescribed for depression rather than chronic pain. The request is not considered medically necessary.

Percocet 10/325mg 1-2 tab po every 4-6 hrs #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (1) Opioids, criteria for use, p 76-80 (2) Opioids, dosing, p 86 Page(s): 76-80, 86. Decision based on Non-MTUS Citation Farrar JT, Young JP, LaMoreaux L, Werth JL, Poole RM. Clinical importance of changes in chronic pain intensity measured on an 11-point numerical pain rating scale. Pain. 2001 Nov; 94 (2): 149-58.

Decision rationale: The claimant sustained a work injury in May 2012 and continues to be treated for low back pain. She underwent a lumbar discectomy in February 2014. In June 2015, medications are referenced as decreasing pain from 8-9/10 only down to 7/10. On 07/29/15, she had completed physical therapy and acupuncture treatments. She was having worsening pain. She was not receiving medications. Physical examination findings included an antalgic gait. There was lumbar spine and bilateral posterior superior iliac spine stiffness, tightness, and pain. There was decreased left lower extremity strength and sensation. Medications were prescribed. Percocet (oxycodone/acetaminophen) is a short acting combination opioid often used for intermittent or breakthrough pain. In this case, it is being prescribed as part of the claimant's ongoing management. Although there are no identified issues of abuse or addiction and the total MED is less than 120 mg per day, there is no documentation that this medication is providing a clinically significant decrease in pain, an increased level of function, or improved quality of life. Continued prescribing was not medically necessary.