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| Case Number: | CM15-0196046 | | |
| Date Assigned: | 10/09/2015 | Date of Injury: | 10/20/1994 |
| Decision Date: | 11/18/2015 | UR Denial Date: | 09/10/2015 |
| Priority: | Standard | Application Received: | 10/06/2015 |

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: Arizona, 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 66 year old male who sustained an industrial injury on 10-20-94. A review of the medical records indicates he is undergoing treatment for multiple level lumbar disc disease, history, per injured worker, of pulmonary scarring and right sided failure, depression, sleep disturbance secondary to pain, narcotic surveillance, intermittent suicidal ideation, renal failure, lumbar facet syndrome, and causalgia. Medical records (2-2-15 to 8-25-15) indicate ongoing complaints of right upper thigh and hip pain. His pain rating has ranged from "3-8 out of 10". The records indicate that he "continues to be able to exercise and is still walking and better able to do household chores". The records also indicate that the weather influences his pain, worse with cold weather, better with warmer weather. The physical exam (8-25-15) reveals weakness in right plantar flexion "4 out of 5", lumbar flexion of 75%, extension 90%. Positive straight leg raise on the right at 50% in sitting and supine positions. Pain is noted on the right L2-3 and L3-4 facets and the right sacroiliac joint. Treatment has included radiofrequency ablation of L3, L4, and L5 bilaterally, as well as medications. His current (8-25-15) medications include Lantus, Simvastatin, Amlodipine, Allopurinol, Lasix, Venlafaxine, Trazodone, Potassium, Diltiazem, "Acid blocker", MSER 20mg up to 6 x per day, Metformin, Diclofenac patch, and "kidney meds". He has been receiving Trazodone since, at least, 9-26-08 and MSER since, at least, 4-24-14. The request for authorization (992915) includes a CT scan of the right sacroiliac joint, a lumbar MRI, MSER 20mg for use up to 6 per day #180, and Trazodone 100mg #120. The utilization review (9-10-15) indicates denial of the CT scan of the sacroiliac joint and Trazodone. Modification of MSER was made to a quantity of 60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Computed tomography (CT) scan of the right sacroiliac joint: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Hip & Pelvis Procedure Summary - Indications for imaging - Computed tomography.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Summary. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) hip chapter and pg 13.

Decision rationale: According to the guidelines, CT of the SI joint/hip is indicated for: Sacral insufficiency fractures; Suspected osteoid osteoma; Subchondral fractures; Failure of closed reduction. In this case, the claimant has facet pain in the lumbar spine and SI joint. An MRI was requested as well of the lumbar spine. There was no indication of SI fracture, plan for surgery or any red flag findings. The request for an SI CT is not medically necessary.

MSER (morphine sulfate extended release) 20mg, #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain, Opioids for neuropathic pain, Oral morphine.

Decision rationale: According to the guidelines, Morphine is not 1st line for mechanical pain. Although it may be used for chronic pain, the dose should not exceed 120 mg. In this case, the claimant's does of MSER exceeded 120 mg. In addition, the claimant's pain score range of 3-7/10 on the medication was a wide range. The claimant was on the same does without mention of weaning failure. The continued use of MSER is not medically necessary.

Trazodone 100mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain, SSRIs (selective serotonin reuptake inhibitors).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) mental chapter and pg 16pain chapter and pg 64.

Decision rationale: Trazadone is a tricyclic antidepressant. According to the MTUS guidelines, this class of medications is to be used for depression, radiculopathy, back pain, and

fibromyalgia. Tricyclic antidepressants have been shown in both a meta-analysis and a systematic review to be effective, and are considered a first-line treatment for neuropathic pain. The ODG guidelines indicate they may be used for depression. In this case, the Trazadone helped the claimant sleep well. Although the claimant had depression, the use of Trazadone and its effectiveness for back pain or sleep was not specified. The Trazadone was not justified based on medical evidence for its approved use and is not medically necessary.