

Case Number:	CM15-0207321		
Date Assigned:	10/26/2015	Date of Injury:	05/18/2000
Decision Date:	12/07/2015	UR Denial Date:	09/22/2015
Priority:	Standard	Application Received:	10/21/2015

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 47 year old male who sustained an industrial injury on 05-18-2000. A review of the medical records indicated that the injured worker is undergoing treatment for cervical radiculopathy, chronic pain syndrome, left hallux valgus deformity, neuropraxia left medial digital nerve of the great toe and insomnia. The injured worker is status post cervical spine fusion C5-C7 (no date documented) and left foot first metatarsophalangeal joint-sesamoid bone fracture (no date documented). According to the treating physician's progress report on 08-24-2015, the injured worker continues to experience neck pain radiating down the left upper extremity to the fingers associated with weakness, numbness and tingling, bilateral occipital headaches and low back pain radiating to the bilateral thighs to the toes with numbness and tingling. The injured worker rated his average pain without medications at 10 out of 10 and 7 out of 10 on the pain scale with medications. The injured worker also reported moderate nausea. Examination demonstrated tenderness to palpation in the bilateral paravertebral area of L4-S1 with limited range of motion due to pain which significantly increased with flexion and extension. Facet signs were present in the lumbar spine bilaterally. The left lower extremity examination demonstrated tenderness to palpation and mild swelling at the left foot with deformity of the great toe. No allodynia or discoloration in the left lower extremity was evident. There was no objective findings related to the cervical spine. Prior treatments have included diagnostic testing, surgery, acupuncture therapy, physical therapy, radiofrequency rhizotomy at L5-S1 in 2013 and medications. Current medications were listed as Percocet (since at least 01-2015), Trazodone (since at least 01-2015) and Gabapentin. Treatment plan consists of physical therapy and ongoing home exercise program, radiofrequency rhizotomy at L4-S1 and the current request for Percocet 10mg-325mg #150 and Trazodone 50mg #30. The Utilization Review modified the request for Percocet 10mg-325mg #150 to Percocet 10mg-325mg #112 and determined the request for Trazodone 50mg #30 was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg #150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): 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.

Decision rationale: Percocet is a short acting opioid used for breakthrough pain. According to the MTUS guidelines, it is not indicated as 1st line therapy for neuropathic pain, and chronic back pain. It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. In this case, the claimant had been on Percocet for several months. There was no mention of Tylenol, NSAID, or weaning failure. The continued use of Percocet is not medically necessary.

Trazodone 50mg #30: Upheld

Claims Administrator 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), Pain Chapter.

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) pain chapter and pg 64.

Decision rationale: Trazodone 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. It has not been proven beneficial for lumbar root pain. In this case, the Trazodone was provided for insomnia. There was no mention of failure of 1st line medications or behavioral modifications. Continued use of Trazodone is not medically necessary.