

Case Number:	CM15-0218140		
Date Assigned:	11/10/2015	Date of Injury:	01/08/2013
Decision Date:	12/21/2015	UR Denial Date:	10/12/2015
Priority:	Standard	Application Received:	11/05/2015

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: Physical Medicine & Rehabilitation

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 73-year-old male who sustained an industrial injury 01-08-13. A review of the medical records reveals the injured worker is undergoing treatment for lumbosacral spondylosis, lumbar spinal stenosis, and long term use of medications. Medical records (08-07-15) reveal the injured worker complains of chronic low back pain with radicular symptoms into his right lower extremity. He reports 30% pain decrease with Buprenorphine. His pain is not rated. The physical exam (08-07-15) reveals normal muscle tone without atrophy in all extremities. Prior treatment includes epidural steroid injections, medial branch facet blocks, medications including Buprenorphine, gabapentin Protonix, and Trazadone, as well as muscle relaxants, ibuprofen and naproxen. The original utilization review (10-12-15) non-certified the request for Trazadone 50mg #45 (05-05-15) and #90 (08-07-15) and Buprenorphine 0.1mg SL troches #30 with 1 refill. The documentation supports that the injured worker has been on Trazadone and Buprenorphine since at least 03-03-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective: Remaining #45 tablets of Trazodone 50mg (dos 5/5/15): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Mental illness & stress chapter).

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

Decision rationale: Trazodone hydrochloride (Desyrel) is an antidepressant chemically unrelated to tricyclic, tetracyclic, or other known antidepressant agents, and is indicated for diagnosis of major depression. MTUS Medical Treatment Guidelines recommend antidepressant as a first line option for neuropathic and possibly for non-neuropathic chronic pain, but has no specific recommendation for Trazodone. Tolerance may develop and rebound insomnia has been found even after discontinuation from use; however, Trazodone may be an option in patients with coexisting diagnosis of major depression which has not been established here. Submitted reports have not demonstrated outcome benefit nor are there identified efficacy in terms of increased functional ability, increased ADLs, decreased VAS scores, decreased pharmacological dependency or medical utilization derived from the previous treatment rendered for this chronic 2013 injury. The Retrospective: Remaining #45 tablets of Trazodone 50mg (dos 5/5/15) is not medically necessary and appropriate.

Buprenorphine 0.1mg sublingual troches #30 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

Decision rationale: Review indicates the request for Buprenorphine was modified for weaning purposes. Submitted reports have not demonstrated the indication or medical necessity for this medication request. Per MTUS Chronic Pain, Buprenorphine is a scheduled III controlled substance recommended for treatment of opiate addiction or opiate agonist dependence. Request has been reviewed previously and non-certified for rationale of lack of pain contract, indication, and documentation of opioid addiction. Buprenorphine has one of the most high profile side effects of a scheduled III medication. Per the Guidelines, opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial and use should be reserved for those with improved attributable functional outcomes. This is not apparent here as this patient reports no change in VAS level documented, no functional improvement in daily activities, and has not decreased in medical utilization or self-independence continuing to treat for chronic pain symptoms. There is also no notation of any functional improvement while on the medication nor is there any recent urine drug screening results in accordance to pain contract needed in this case. Without sufficient monitoring of narcotic safety, efficacy, and compliance for this individual along with no weaning process attempted for this chronic January 2013 injury. Medical necessity for continued treatment has not been established for Buprenorphine. The Buprenorphine 0.1mg sublingual troches #30 with 1 refill is not medically necessary and appropriate.

Retrospective: Trazodone 50mg #90 (dos 8/7/15): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Mental Illness & stress chapter).

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

Decision rationale: Trazodone hydrochloride (Desyrel) is an antidepressant chemically unrelated to tricyclic, tetracyclic, or other known antidepressant agents, and is indicated for diagnosis of major depression. MTUS Medical Treatment Guidelines recommend antidepressant as a first line option for neuropathic and possibly for non-neuropathic chronic pain, but has no specific recommendation for Trazodone. Tolerance may develop and rebound insomnia has been found even after discontinuation from use; however, Trazodone may be an option in patients with coexisting diagnosis of major depression, which has not been established here. Submitted reports have not demonstrated outcome benefit nor are there identified efficacy in terms of increased functional ability, increased ADLs, decreased VAS scores, decreased pharmacological dependency or medical utilization derived from the previous treatment rendered for this chronic injury. The Retrospective: Trazodone 50mg #90 (dos 8/7/15) is not medically necessary and appropriate.