

<b>Case Number:</b>	CM15-0037511		
<b>Date Assigned:</b>	03/05/2015	<b>Date of Injury:</b>	11/28/2008
<b>Decision Date:</b>	04/21/2015	<b>UR Denial Date:</b>	02/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/27/2015

### 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 53 year old male, who sustained an industrial injury on 11/28/2008. The current diagnosis is chronic low back pain and right lower extremity pain with weakness. Currently, the injured worker complains of chronic low back pain. The pain is rated 6/10 with medications and 8-10/10 without. Current medications are OxyContin, Morphine Sulfate, Baclofen, Trazadone, Wellbutrin, and Zanaflex. The physical examination reveals pain in the lower back region with forward flexion and extension. There is weakness in the right leg with dorsiflexion and plantar flexion of the foot. Treatment to date has included medications. MRI of the lumbar spine (11/22/2013) shows multiple small bulging discs, overall mildly worsened since 2009. The treating physician is requesting OxyContin 30 mg #90, Morphine sulfate 15 mg #30, and Trazadone 50 mg #30, which is now under review. On 2/13/2015, Utilization Review had non-certified a request for OxyContin 30 mg #90, Morphine sulfate 15 mg #30, and Trazadone 50 mg #30. The California MTUS ACOEM and Official Disability Guidelines were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**OxyContin 30 mg #90 three times a day: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing management Page(s): 78-80.

**Decision rationale:** OxyContin 30 mg #90 three times a day is not medically necessary per the MTUS Guidelines. The MTUS Chronic Pain Medical Treatment Guidelines state: that a pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The MTUS does not support ongoing opioid use without improvement in function or pain. The documentation submitted reveals that the patient has been on long term opioids without significant functional improvement as defined by the MTUS therefore the request for OxyContin 30 mg #90 three times a day is not medically necessary.

**Morphine sulfate 15 mg #30 one a day as needed:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing management Page(s): 78-80.

**Decision rationale:** Morphine sulfate 15 mg #30 one a day as needed is not medically necessary per the MTUS Guidelines. The MTUS Chronic Pain Medical Treatment Guidelines state: that a pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The MTUS does not support ongoing opioid use without improvement in function or pain. The documentation submitted reveals that the patient has been on long term opioids without significant functional improvement as defined by the MTUS therefore the request for Morphine sulfate 15 mg #30 one a day as needed is not medically necessary.

**Trazadone 50 mg #30 with 1 refill daily at bedtime:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG.

**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 and stress: Trazodone (Desyrel).

**Decision rationale:** Trazodone 50 mg #30 with 1 refill daily at bedtime is not medically necessary per the Official Disability Guidelines. The MTUS does not address insomnia or this request. The ODG states that Trazadone is recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. The documentation does not reveal clinical diagnoses of depression or anxiety therefore this medication is not medically necessary.