MAXIMUS Federal Services

Case Number:	CM15-0046778		
Date Assigned:	03/19/2015	Date of Injury:	05/08/2001
Decision Date:	05/01/2015	UR Denial Date:	03/02/2015
Priority:	Standard	Application Received:	03/11/2015

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 68 year old male, who sustained an industrial injury on 5/8/01. The injured worker has complaints of neck pain, headaches, low back pain, left lower extremity radicular pain, left upper extremity radicular pain, depression, insomnia secondary to pain. The documentation noted that the urine toxicology screen from 12/29/14 was appropriate. The documentation noted that the injured worker has a signed opiate agreement on the chart and the opiate risk tool has been applied. The diagnoses have included cervical spondylosis; depression/ anxiety; headache; lumb/lumbosac disc degeneration and neuropathy. The requested treatments were for Hydrocodone Acetaminophen 10/325mg #120 and Trazodone 50mg #60 with 1 refill.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone Acetaminophen 10/325mg #120: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: According to the 02/23/2015 report, this patient presents with "neck pain, headaches, low back pain, left lower extremities radicular pain, left upper extremity radicular pain, depression, insomnia secondary to pain." The current request is for Hydrocodone Acetaminophen 10/325mg #120. This medication was first mentioned in the 02/08/2013 report; it is unknown exactly when the patient initially started taking this medication. The request for authorization is on 02/23/2015.The patient's work status was not mentioned in the provided reports. For chronic opiate use, MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4A's; analgesia, ADLs, adverse side effects, and aberrant behavior, as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. Based on the reports provided for review, the treating physician indicates the patient has no Adverse effect and Aberrant behavior with opiate usage. UDS was obtained in 12/29/2014; "it was appropriate." Patient's pain with medications is a 5/10 and without medications is a 10/10. The Pain Disability Index (PDI) was administered to the patient with the result as follow: The family/home responsibility with medication: 7/10. The family/home responsibility without medication: 10/10. The recreation/social activity/self care with medications: 6/10. The recreation/social activity/self care without medications: 10/10. The sleep quality with medications: 5/10. The sleep quality without medications: 5/10. In this case, the treating physician's report shows proper documentation of the four A's as required by the MTUS guidelines. Therefore, the current request IS medically necessary.

Trazodone 50mg #60 with 1 refill: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Tricyclics Page(s): 13-15. Decision based on Non-MTUS Citation Official disability guidelines stress/mental chapter: Trazodone.

Decision rationale: According to the 02/23/2015 report, this patient presents with "neck pain, headaches, low back pain, left lower extremities radicular pain, left upper extremity radicular pain, depression, insomnia secondary to pain." The current request is for Trazodone 50mg #60 with 1 refill. This medication was first mentioned in the 02/08/2013 report; it is unknown exactly when the patient initially started taking this medication. Regarding antidepressants, MTUS recommends it for neuropathic pain, and as a possibility for non-neuropathic pain. ODG Guidelines, stress/mental chapter, for Trazodone, has the following to say "Recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. See also Insomnia treatment, where it says there is limited evidence to support its use for insomnia, but it may be an option in patients with coexisting depression." In reviewing of the provided reports indicates that the patient is prescribed

Trazadone for apparent depression and/or insomnia. The treating physician states the patient's sleep quality with medications is a 5/10 and without medications is a 5/10. In this case, the patient has depression and insomnia and the treating physician documented the efficacy of the medication as required by the MTUS guidelines. The current request IS medically necessary.