

<b>Case Number:</b>	CM15-0068755		
<b>Date Assigned:</b>	04/16/2015	<b>Date of Injury:</b>	04/19/1992
<b>Decision Date:</b>	07/13/2015	<b>UR Denial Date:</b>	03/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/10/2015

### 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: Utah, Arkansas

Certification(s)/Specialty: Family Practice, Sports 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 68 year old female patient who sustained an industrial injury on 04/19/1992. A recent office visit dated 03/18/2015 reported the patient with subjective complaints of ongoing low back and thoracic pain. On 01/21/2015 the patient continued with subjective complaint of ongoing low back pain and thoracic pain. Current medications are: Vicoprofen, Ultracet, Neurontin, Trazadone, Effexor, and Colace. Objective findings showed no significant change. There is no change in the treating diagnoses of chronic low back pain and lower thoracic pain. She was given one months' supply of Vicoprofen, Neurontin, Trazadone, and Effexor. The doctor is with recommendation for a back brace. She is to continue with exercising and follow up in a month.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**5 Retrospective (DOS 2/18/15) review for Vicoprofen 7.5/200mg 3 times a day #60 number of refills not specified:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 75-79.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The MTUS indicates that ongoing management of opioids includes documentation of prescriptions given from a single practitioner, prescriptions from a single pharmacy and the lowest dose should be used to improve function. There should also be an ongoing review of the 4 A's, including analgesia, activities of daily living, adverse side effects, and aberrant drug behaviors. This has been documented in the clinical records, and it appears that this medication has given functional gain to the patient. According to the clinical documentation provided and current MTUS guidelines; Vicoprofen, as written above, is indicated a medical necessity to the patient at this time.

**5 Retrospective (DOS 2/18/15) review Ultracet 37.5/325mg twice a day # 60 number of refills not specified:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 75-79.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The MTUS indicates that ongoing management of opioids includes documentation of prescriptions given from a single practitioner, prescriptions from a single pharmacy and the lowest dose should be used to improve function. There should also be an ongoing review of the 4 A's, including analgesia, activities of daily living, adverse side effects, and aberrant drug behaviors. This has been documented in the clinical records, and it appears that this medication has given functional gain to the patient. According to the clinical documentation provided and current MTUS guidelines; Ultracet, as written above, is indicated a medical necessity to the patient at this time.

**5 Retrospective (DOS 2/18/15) review Neurontin 800mg 3 times a day # 90 number of refills not specified:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs Page(s): 16 and 49.

**Decision rationale:** MTUS guidelines were reviewed in regards to this specific case. Clinical documents were reviewed. According to the above cited guidelines, "Most randomized controlled trials (RCTs) for the use of this class of medication for neuropathic pain have been directed at postherpetic neuralgia and painful polyneuropathy (with diabetic polyneuropathy being the most common example). There are few RCTs directed at central pain and none for

painful radiculopathy." To determine a good outcome, "A 'good' response to the use of AEDs has been defined as a 50% reduction in pain and a 'moderate' response as a 30% reduction." "It has been reported that a 30% reduction in pain is clinically important to patients and a lack of response of this magnitude may be the 'trigger' for the following: (1) a switch to a different first-line agent (TCA, SNRI or AED are considered first-line treatment); or (2) combination therapy if treatment with a single drug agent fails." There is no documentation that states the patient has a radicular/nerve pain. According to the clinical documentation provided and current MTUS guidelines, Neurontin is medically necessary to the patient at this time.

**5 Retrospective (DOS 2/18/15) review Trazodone 50mg at bedtime #60 number of refills not specified:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, mental Illness and Stress.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Trazadone.

**Decision rationale:** MTUS treatment guidelines are silent with regards to the above request. Other guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Trazadone. Guidelines state the following: indicated for insomnia for those patient with a concurrent diagnosis of depression or anxiety. The clinical documents lack statements that the patient meets the above criteria. According to the clinical documentation provided and current guidelines; Trazadone is not medically necessary to the patient at this time.

**5 Retrospective (DOS 2/18/15) review Effexor 75mg once a day #30, number of refills not specified:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation uptodate.com Effexor.

**Decision rationale:** Other guidelines were reviewed in regards to this specific case. Clinical documents were reviewed. Guidelines state the following: indicated for neuropathic pain, or a diagnosis of depression or anxiety. The clinical documents lack statements that the patient meets the above criteria. There is no documentation that states the patient has a radicular/nerve pain. According to the clinical documentation provided and current guidelines, Effexor is not medically necessary to the patient at this time.