

Case Number:	CM14-0179905		
Date Assigned:	11/04/2014	Date of Injury:	07/05/2010
Decision Date:	12/16/2014	UR Denial Date:	10/14/2014
Priority:	Standard	Application Received:	10/29/2014

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. The expert reviewer is Board Certified in Anesthesia, has a subspecialty in Acupuncture & Pain Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 51 years old female worker with related back pain was date of injury 7/5/10. Per progress report dated 9/3/14, the injured worker complained of back pain radiating from the low back down the right leg, as well as lower backache and right foot pain. She rated her low back pain 6/10 and her right foot pain 8/10 in intensity. She also complained of pain in the neck radiating down into the right shoulder which she rated 5/10. She also complained of headaches and rated the pain 3/10. Per physical exam, there was tenderness to palpation of the paravertebral muscles, tight muscle band and trigger point on the left side. Straight leg raise test was positive on the right side. Treatment to date has included TENS unit, physical therapy, and medication management.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazodone tab 50mg Day supply: 30, refills: 2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) 6, page(s) Chronic Pain

Decision rationale: Per the ACOEM guidelines: "Trazodone is strongly not recommended for treatment of chronic persistent pain without depression." The medical records submitted for review do not document this medication as used for depression. As Trazodone is not recommended, the request is not medically necessary.

Butrans DIS 10 mcg/hr Day supply: 28, Quantity: 4, Refills: 0: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine Page(s): 26-27, 78.

Decision rationale: With regard to Buprenorphine, the MTUS CPMTG states: "recommended as an option for chronic pain, especially after detoxification in patients who have a history of opiate addiction (see below for specific recommendations). A schedule-III controlled substance, buprenorphine is a partial agonist at the mu-receptor (the classic morphine receptor) and an antagonist at the kappa-receptor (the receptor that is thought to produce alterations in the perception of pain, including emotional response). In recent years, buprenorphine has been introduced in most European countries as a transdermal formulation ("patch") for the treatment of chronic pain. Proposed advantages in terms of pain control include the following: (1) No analgesic ceiling; (2) A good safety profile (especially in regard to respiratory depression); (3) Decreased abuse potential; (4) Ability to suppress opioid withdrawal; & (5) An apparent antihyperalgesic effect (partially due to the effect at the kappa-receptor)." Per MTUS Chronic Pain Medical Treatment Guidelines p76 regarding therapeutic trial of opioids, questions to ask prior to starting therapy include "(a) Are there reasonable alternatives to treatment, and have these been tried? (b) Is the patient likely to improve? (c) Is there likelihood of abuse or an adverse outcome?" As this is the first time Butrans is being prescribed, there has not been enough time to evaluate for functional improvement. I respectfully disagree with the UR physician, the request is medically necessary.

Pennsaid Solution 2% Day supply: 30, Quantity: 224, Refills: 0: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: Pennsaid is diclofenac topical solution and topical DMSO. With regard to topical diclofenac sodium, the MTUS states: "Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder." The documentation submitted for review contained no evidence of osteoarthritis or joint pain for which the request would be indicated. The request is not medically necessary.