

Case Number:	CM14-0201866		
Date Assigned:	12/12/2014	Date of Injury:	05/08/2001
Decision Date:	01/29/2015	UR Denial Date:	11/14/2014
Priority:	Standard	Application Received:	12/02/2014

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 Physical Medicine Rehabilitation 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:

This 68 year-old patient sustained an injury on 5/8/2001 while employed by [REDACTED]. Request(s) under consideration include 1 prescription of Hydrocodone-Acetaminophen 10/325mg #120 and 1 prescription of Trazodone 50mg #60. Diagnoses include cervical spondylosis/ disc displacement; lumbar disc displacement/ radiculopathy; depression; and sleeping disorder. Conservative care has included medications, therapy, spinal cord stimulator, and modified activities/rest. Report from the provider noted the patient with chronic ongoing symptom complaints. It was noted medications improve the patient's sleep and functional activities with pain rated from 10/10 to 8/10. Exam remained unchanged with diffuse tenderness in the cervical and lumbar spine, trapezius with decreased sensation at right L4, L5; spasm and some spasticity. Treatment plan include continued medications which list AndroGel, Cymbalta, Norco, Trazodone, and Oxymorphone. The request(s) for 1 prescription of Hydrocodone-Acetaminophen 10/325mg #120 was modified for weaning and 1 prescription of Trazodone 50mg #60 was non-certified on 11/14/14 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Hydrocodone-Acetaminophen 10/325mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Page(s): 74-96.

Decision rationale: Per the MTUS Guidelines cited, opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial. Patients on opioids should be routinely monitored for signs of impairment and use of opioids in patients with chronic pain should be reserved for those with improved functional outcomes attributable to their use, in the context of an overall approach to pain management that also includes non-opioid analgesics, adjuvant therapies, psychological support, and active treatments (e.g., exercise). Submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated improvement in daily activities, decreased in medical utilization or change in functional status. There is no evidence presented of random drug testing or utilization of pain contract to adequately monitor for narcotic safety, efficacy, and compliance. The MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. From the submitted reports, there is no demonstrated evidence of specific functional benefit derived from the continuing use of opioids with persistent severe pain for this chronic injury without acute flare, new injury, or progressive deterioration. The request for 1 prescription of Hydrocodone-Acetaminophen 10/325mg #120 is not medically necessary and appropriate.

1 prescription of Trazodone 50mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS Official Disability Guidelines (ODG), Mental Illness & Stress.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressant for Chronic Pain, Anti-depressants for Treatment of Chronic Persistent Pain; Inso.

Decision rationale: Trazodone hydrochloride (Desyrel) is an antidepressant chemically unrelated to tricyclic, tetracyclic, or other known antidepressant agents and is indicated for the treatment of major depression. MTUS Medical Treatment Guidelines specifically do not recommend for Trazodone. Tolerance may develop and rebound insomnia has been found even after discontinuation, but may be an option in patients with coexisting depression that is not the case here. Submitted reports have not demonstrated functional benefit derived from the previous treatment rendered for this chronic injury of 2001. In order to provide a specific treatment method, the requesting physician must provide clear objective documentation for medical indication, functional improvement goals' expected or derived specifically relating to the patient's condition as a result of the treatment(s) provided. Documentation of functional improvement may be a clinically significant improvement in activities of daily living, a reduction in work restrictions and a reduction in the dependency on continued medical treatment. Absent the above described documentation, there is no indication that the specific treatment method is effective or medically necessary for this patient. The request for 1 prescription of Trazodone 50mg #60 is not medically necessary and appropriate.

