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| <b>Case Number:</b>   | CM14-0214460 |                              |            |
| <b>Date Assigned:</b> | 01/07/2015   | <b>Date of Injury:</b>       | 08/09/2013 |
| <b>Decision Date:</b> | 02/19/2015   | <b>UR Denial Date:</b>       | 11/27/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 12/22/2014 |

### 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. 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: Internal Medicine, Rheumatology

### 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 patient is a 57 year old male with date of injury 8/9/2013. The mechanism of injury is not stated in the available medical records. The patient has complained of low back pain with radiation of the pain to the right lower extremity and right shoulder pain since the date of injury. He has been treated with physical therapy and medications. There are no radiographic reports included for review. Objective: decreased and painful range of motion of the lumbar spine, tenderness to palpation of the paraspinous lumbar musculature, decreased sensation in the left L4, L5 dermatome. Diagnoses: lumbar sprain/strain, lumbosacral radiculitis, spinal stenosis, lumbar degenerative joint disease. Treatment plan and request: Norco, Trazodone, Ativan.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325 mg #90:** Upheld

**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): 76-85, 88-89.

**Decision rationale:** This 57 year old male has complained of low back pain with radiation of pain to the right lower extremity and right shoulder pain since date of injury 8/9/13. He has been treated with physical therapy and medications to include opioids since at least 07/2014. No treating physician reports adequately assess the patient with respect to function, specific benefit, return to work, signs of abuse or treatment alternatives other than opioids. There is no evidence that the treating physician is prescribing opioids according to the MTUS section cited above which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, opiod contract and documentation of failure of prior non-opioid therapy. On the basis of this lack of documentation and failure to adhere to the MTUS guidelines, Norco is not indicated as medically necessary.

**Trazodone 100 mg #30 with 2 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants Page(s): 13-14.

**Decision rationale:** This 57 year old male has complained of low back pain with radiation of pain to the right lower extremity and right shoulder pain since date of injury 8/9/13. He has been treated with physical therapy and medications to include Trazadone since at least 08/2014. The current request is for Trazadone. There is inadequate documentation in the available medical records regarding the use and efficacy of trazadone in this patient. Trazadone is approved for the treatment of depression. There is no documentation of any subjective or objective findings of anxiety or depression in this patient. On the basis of this lack of medical documentation Trazadone is not indicated as medically necessary in this patient.

**Ativan 1 mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** This 57 year old male has complained of low back pain with radiation of pain to the right lower extremity and right shoulder pain since date of injury 8/9/13. He has been treated with physical therapy and medications to include Ativan since at least 07/2014. The current request is for Ativan. There is no discussion in the available medical records regarding the indications for use of Ativan in this patient. On the basis of this lack of documentation, Ativan is not indicated as medically necessary in this patient.