

<b>Case Number:</b>	CM14-0217592		
<b>Date Assigned:</b>	01/07/2015	<b>Date of Injury:</b>	09/20/1996
<b>Decision Date:</b>	05/29/2015	<b>UR Denial Date:</b>	12/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/29/2014

### 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. 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, Arizona

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 58 year old, male who sustained a work related injury on 09/20/1996. The diagnoses have included status post lumbar fusion, lumbar spine myospasms, lumbar facet arthropathy and status post spinal cord stimulator implantation. Treatments have included spinal cord stimulator use, medications, physical therapy, acupuncture treatments and injections, all with minimal benefit. In the PR-2 dated 11/18/2014, the injured worker complains of pain in the left side of body from shoulder blade to low back and down left leg to foot. He rates his pain a 6/10 on medications. He has difficulty performing activities without medications. There was no comprehensive physical examination provided on the requesting date. The treatment recommendations included a refill of Xanax 0.5 mg, trazodone 100 mg, Percocet 10/325 mg and fentanyl 50 mg. A Request for Authorization form was submitted on 11/18/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Trazodone 100mg with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines anti-depressant Page(s): 13-16.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress Chapter, Trazodone (Desyrel).

**Decision rationale:** The Official Disability Guidelines recommend trazodone as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms, such as depression and anxiety. In this case, the injured worker does not maintain a diagnosis of insomnia, depression or anxiety. The injured worker has continuously utilized the above medication since at least 07/2014. The medical necessity for the ongoing use of trazodone 100 mg has not been established in this case. There is also no frequency or quantity listed in the request. Given the above, the request is not medically necessary.

**10 patches of Fentanyl 50mcg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-95.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44.

**Decision rationale:** The California MTUS Guidelines do not recommend fentanyl transdermal system as a first line therapy. Fentanyl transdermal system is indicated the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. In this case, the injured worker has continuously utilized the above medication since at least 07/2014. There is no documentation of objective functional improvement. There is also no evidence of a failure of first line treatment. Given the above, the request is not medically necessary.

**Xanax 0.5mg with 30 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines benzodiazepines Page(s): 24.

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

**Decision rationale:** The California MTUS Guidelines do not recommend long-term use of benzodiazepines, because long-term efficacy has been unproven and there is a risk of dependence. The injured worker has utilized the above medication since 07/2014. There is no mention of functional improvement. There is also no frequency or quantity listed in the request. The request for 30 refills is excessive and would not be supported. Given the above, the request is not medically appropriate.

**Percocet 10/325mg #45:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-95.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until a patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects should occur. The injured worker has utilized the above medication since at least 07/2014. There is no documentation of objective functional improvement. There is also no frequency listed in the request. Given the above, the request is not medically appropriate.