

Case Number:	CM15-0012844		
Date Assigned:	01/30/2015	Date of Injury:	12/04/1997
Decision Date:	03/18/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/22/2015

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: California

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 57 year old female with an industrial injury dated 12/04/1997. Her diagnoses include chronic pain syndrome, thoracic or lumbosacral neuritis or radiculitis, unspecified, and pathologic fracture, unspecified site. Recent diagnostic testing was not provided or discussed. She has been treated with medications and conservative care. In a progress note dated 12/09/2014, the treating physician reports burning low back pain with radiating factors to the right buttock area and a pain level without medications of 6/10 despite treatment. The objective examination revealed use of profanity and tearfulness, and tenderness to the lumbar region. The treating physician is requesting multiple medications which were denied by the utilization review. On 12/23/2014, Utilization Review non-certified a prescription for trans 20mcg/hour (1 patch every 7 days) #4 with no refills, noting the absence of toxicology testing and lack of documented rationale why this medication was prescribed in place of recommended first-line treatments. The ODG Guidelines were cited. On 12/23/2014, Utilization Review non-certified a prescription for Trazodone 100mg (1 by mouth every 8 hours) #30 with no refills, noting the recommendation for short term to intermediate term of duration in the treatment of muscle pain and spasm. The ODG, ACOEM and non-MTUS Guidelines were cited. On 12/23/2014, Utilization Review non-certified a prescription for Xanax 1mg (1 by mouth 3 times per day) #90 with no refills for the management related to lumbar spine pain as an outpatient, noting the absence of relationship of this medications to the compensable injury, excessive duration of use, and drug interaction with other prescribed medications. The ODG, ACOEM and non-MTUS Guidelines were cited. On 01/22/2015, the injured worker submitted an application

for IMR for review of Butrans 20mcg/hour (1 patch every 7 days) #4 with no refills, Trazodone 100mg (1 by mouth every 8 hours) #30 with no refills, and Xanax 1mg (1 by mouth 3 times per day) #90 with no refills for the management related to lumbar spine pain as an outpatient.

IMR ISSUES, DECISIONS AND RATIONALES

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

Butrans 20 MCG/Hr, 1 Patch Every 7 Days Qty 4 with No Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine HCL, pages 26-27.

Decision rationale: Submitted reports have not demonstrated the indication or medical necessity for this medication request. Per MTUS Chronic Pain, BuTrans or Buprenorphine is a scheduled III controlled substance recommended for treatment of opiate addiction or opiate agonist dependence. Request has been reviewed previously and non-certified for rationale of lack of pain contract, indication, and documentation of opioid addiction. Buprenorphine has one of the most high profile side effects of a scheduled III medication. Per the Guidelines, opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial and use should be reserved for those with improved attributable functional outcomes. This is not apparent here as this patient reports no change in pain relief, no functional improvement in daily activities, and has not decreased in medical utilization or self-independence continuing to treat for chronic pain symptoms. There is also no notation of any functional improvement while on the patch nor is there any recent urine drug screening results in accordance to pain contract needed in this case. Without sufficient monitoring of narcotic safety, efficacy, and compliance for this individual along with no weaning process attempted for this chronic injury. Medical necessity for continued treatment has not been established for Buprenorphine. The Butrans 20 MCG/Hr, 1 Patch Every 7 Days Qty 4 with No Refills is not medically necessary and appropriate.

Trazodone 100 MG, Take 1 By Mouth Every 8 Hours, Qty 30 with No Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressant for Chronic Pain, 13-16.

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. The Trazodone 100 MG, Take 1 By Mouth Every 8 Hours, Qty 30 with No Refills is not medically necessary and appropriate.

Xanax 1 MG, Take 1 By Mouth, 3 Times A Day, Qty 90 with No Refills for Management Related to Lumbar Spine, As An Outpatient: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines, page 24.

Decision rationale: There is no report of acute exacerbation or new injuries reported. Xanax Tablets (alprazolam) is indicated for the management of anxiety disorder. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Alprazolam is an anti-anxiety medication in the benzodiazepine family which inhibits many of the activities of the brain as it is believed that excessive activity in the brain may lead to anxiety or other psychiatric disorders. Per the Chronic Pain Treatment Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks as chronic benzodiazepines are the treatment of choice in very few conditions and tolerance to hypnotic effects develops rapidly. The Xanax 1 MG, Take 1 By Mouth, 3 Times A Day, Qty 90 with No Refills for Management Related to Lumbar Spine, As An Outpatient is not medically necessary and appropriate.