

<b>Case Number:</b>	CM15-0110512		
<b>Date Assigned:</b>	06/17/2015	<b>Date of Injury:</b>	03/24/2010
<b>Decision Date:</b>	07/15/2015	<b>UR Denial Date:</b>	06/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/08/2015

### 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: Arizona, California  
 Certification(s)/Specialty: Family Practice

### 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 50 year old female, who sustained an industrial injury on 3/24/2010. The mechanism of injury was moving storage boxes. The injured worker was diagnosed as having cervical 2 spinal fusion, thoracic degenerative disc disease, cervical disc disorder and cervical radiculopathy and low back pain. There is no record of a recent diagnostic study. Treatment to date has included surgery, physical therapy, injections and medication management. In a progress note dated 5/22/2015, the injured worker complains of neck pain, rated 10/10 without medications and 4.5/10 with medications. Physical examination showed restricted range of motion in the cervical spine with tenderness at the paracervical and shoulder muscles, sensory loss in the left lateral foot and good bilateral upper extremity strength. The treating physician is requesting Baclofen 10 mg #30 with 1 refill, Norco 10/325 mg #90 with 1 refill and Trazodone 50 mg #60 with 1 refill.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Baclofen 10 MG #30 with 1 Refill:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Baclofen Page(s): 64.

**Decision rationale:** According to the guidelines, Baclofen is recommended orally for the treatment of spasticity and muscle spasm related to multiple sclerosis and spinal cord injuries. Baclofen has been noted to have benefits for treating lancinating, paroxysmal neuropathic pain such as trigeminal neuralgia. In this case, the claimant does not have the above diagnoses and the continued and chronic use of Baclofen is not medically necessary.

**Norco 10-325 MG #90 with 1 Refill:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 82-92.

**Decision rationale:** Norco is a short acting opioid used for breakthrough pain. According to the MTUS guidelines, it is not indicated as 1st line therapy for neuropathic pain, and chronic back pain. It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. In this case, the claimant had been on Norco for over 2 years without mention of Tylenol or NSAID failure. In addition, there was no indication of weaning failure. The continued use of Norco is not medically necessary.

**Trazodone 50 MG #60 with 1 Refill:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trazodone Page(s): 14-18.

**Decision rationale:** Trazodone is a tricyclic antidepressant. According to the MTUS guidelines, this class of medications is to be used for depression, radiculopathy, back pain, and fibromyalgia. Tricyclic antidepressants have been shown in both a meta-analysis and a systematic review to be effective, and are considered a first-line treatment for neuropathic pain. It has not been proven beneficial for lumbar root pain. In addition, the claimant had been using it at night without specific justification. Trazodone is not indicated for sleep disorders. The claimant does not have the diagnoses above. Continued and prolonged use of Trazodone is not medically necessary.