MAXIMUS Federal Services

Case Number:	CM15-0129809		
Date Assigned:	07/16/2015	Date of Injury:	02/08/2001
Decision Date:	09/10/2015	UR Denial Date:	06/08/2015
Priority:	Standard	Application Received:	07/06/2015

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, Michigan
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 52 year old male, who sustained an industrial injury on 02/08/2001. He has reported subsequent low back and bilateral leg pain and was diagnosed with lumbar degenerative disc disease, L3-L5 stenosis and low back pain. Treatment to date has included medication, bracing, physical therapy and surgery. Percocet and Trazodone were prescribed since at least 12/11/2014. The injured worker underwent fusion, exploration and revision posteriorly of L4-L5, removal of bilateral L4 and L5 pedicle screws and rods at L4-L5, revision bilateral laminectomy of L3-L4 and right L3-L4 with decompression of cauda equina, right L3 and bilateral L4 and L5 nerve roots with use of bone graft harvesting on 01/05/2015. In a progress note dated 04/30/2015, the injured worker complained of increased pain that was rated as 7.5/10 with medications and 9/10 without medications. Sleep quality was noted to be poor and activity level was noted to have decreased. Objective findings were notable for decreased range of motion with pain, spasm, tenderness and tight muscle band of the bilateral paravertebral muscles, inability to walk on the heel or toes, positive straight leg raise on the right side sitting at 50 degrees, decreased sensation to light touch over the bilateral lower extremities and motor testing limited by pain. Medications were noted to allow for self-care and independent living but no specifics were given. Work status was not documented. A request for authorization of Meds x 2: Percocet 10-325 mg tab SIG take 1 every 4 hours as needed (maximum of 6/day) (SAW) quantity of 180 and Trazodone 100 mg SIG 1-2 tablets at hour of sleep as needed quantity of 60 x 2 Ref was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Meds x 2: Percocet 10-325ng tab SIG take 1 every 4 hours as needed (max 6/day) (DAW) Qty 180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 92.

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

Decision rationale: According to the CA MTUS, Percocet (Oxycodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. Guidelines also recommend that dosing not exceed 120 mg of oral morphine equivalents per day. There is no documentation of average pain and duration of pain relief. The documentation submitted shows that Percocet had been prescribed to the injured worker since at least 12/11/2014. There is no evidence of significant objective functional improvement/symptom reduction as indicated by no documented change in work status, unchanged pain levels and either unchanged or decreased activity levels despite medication use. In addition, the morphine equivalent dosage of prescribed opioid medications is greater than the recommended 120 mg per day maximum. Medical necessity of the requested item has not been established. Therefore, the request for authorization of Percocet is not medically necessary.

Trazodone 100mg SIG 1-2 tablets QHS as needed qty 60 x 2 Ref: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 and Stress chapter, Trazodone (Desyrel).

Decision rationale: MTUS is silent regarding the use of Trazodone so alternative guidelines were referenced. As per ODG, Trazodone (Desyrel) is recommended as an option for insomnia, only for patients with co-existing mild psychiatric symptoms such as anxiety or depression. Documentation shows that Trazodone was prescribed to the injured worker since at least 12/11/2014 but the reason for prescription was unclear. There was no psychiatric diagnosis listed. The medication was prescribed for use at the hour of sleep and the injured worker's sleep quality was noted to be poor, so it appears that the medication may have been prescribed for insomnia. Guidelines do not support the use of this medication for insomnia unless there is a co- existing psychiatric condition. In addition, there is no documentation of significant symptom reduction or functional improvement. Sleep quality remained poor and there was no documentation of a change in work status. Therefore, the request for Trazodone is not medically necessary.