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| Case Number: | CM15-0067472 | | |
| Date Assigned: | 04/15/2015 | Date of Injury: | 07/02/2007 |
| Decision Date: | 05/18/2015 | UR Denial Date: | 03/20/2015 |
| Priority: | Standard | Application Received: | 04/09/2015 |

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 55 year old male, who sustained an industrial injury on 07/02/2007. The initial complaints or symptoms included left shoulder pain which was later reported to be the results of damaged cervical disc. The initial official diagnoses were not mentioned in the clinical notes. Treatment to date has included conservative care, medications, x-rays, MRIs, conservative therapies, electrodiagnostic testing, cervical fusion surgeries, and psychiatric/psychological evaluations and therapy. Currently, the injured worker complains of worsening right upper extremity pain. The diagnoses include status post anterior cervical discectomy/fusions (2007 and 2013), lumbar spine musculoligamentous sprain/strain with multilevel spondylosis and retrolisthesis, bilateral shoulder impingement syndrome, and right carpal tunnel syndrome with possible radial neuropathy verses radiculitis. The treatment plan consisted of medications (Norco and Trazodone), planned surgery to the right elbow, and follow-up.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 mg Qty 60: 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 Opioids Page(s): 78, 91.

Decision rationale: Per MTUS Chronic Pain Medical Treatment Guidelines p78 regarding on- going management of opioids "Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: Pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug related behaviors. These domains have been summarized as the '4 A's' (Analgesia, activities of daily living, adverse side effects, and any aberrant drug-taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs." Review of the available medical records reveals insufficient documentation to support the medical necessity of norco nor sufficient documentation addressing the '4 A's' domains, which is a recommended practice for the on-going management of opioids. Specifically, the notes do not appropriately review and document pain relief, functional status improvement, appropriate medication use, or side effects. The MTUS considers this list of criteria for initiation and continuation of opioids in the context of efficacy. It was noted that opioids reduced pain and allowed performance of activities of daily living, however, no specific reduction in VAS or ADLs were documented. Furthermore, efforts to rule out aberrant behavior (e.g. CURES report, UDS, opiate agreement) are necessary to assure safe usage and establish medical necessity. There is no documentation comprehensively addressing this concern in the records available for my review. As MTUS recommends to discontinue opioids if there is no overall improvement in function, medical necessity cannot be affirmed.

Trazodone 50 mg (qty unspecified): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Mental Illness & Stress; Pain (Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain (Chronic), Insomnia Treatment.

Decision rationale: With regard to insomnia treatment, the ODG guidelines state "Sedating antidepressants (e.g., amitriptyline, trazodone, mirtazapine) have also been used to treat insomnia; however, there is less evidence to support their use for insomnia (Buscemi, 2007) (Morin, 2007), but they may be an option in patients with coexisting depression. (Morin, 2007) Trazodone is one of the most commonly prescribed agents for insomnia. Side effects of this drug include nausea, dry mouth, constipation, drowsiness, and headache. Improvements in sleep onset may be offset by negative next-day effects such as ease of awakening. Tolerance may develop and rebound insomnia has been found after discontinuation." The documentation submitted for review does not provide information regarding sleep onset, sleep maintenance, sleep quality or next day functioning to support the medical necessity of a sleep aid. It is noted that the injured worker suffers from depression. However, there was no documentation of medication efficacy. Furthermore, the quantity requested is not specified. The request is not medically necessary.