

Case Number:	CM15-0074446		
Date Assigned:	04/24/2015	Date of Injury:	09/20/1996
Decision Date:	06/11/2015	UR Denial Date:	03/16/2015
Priority:	Standard	Application Received:	04/20/2015

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: Maryland

Certification(s)/Specialty: Internal Medicine, Rheumatology

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 (IW) is a 59-year-old male who sustained an industrial injury on 09/20/1996. He reported back pain. The injured worker was diagnosed as having: Intractable pain; status post lumbar fusion L4-5 and L5-S1 with subsequent removal of hardware; persistent myospasm, lumbar spine; facet arthropathy, L3-4; status post spinal cord stimulator implantation with paddle lead at T10 (2006). Treatment to date has included medications, and therapeutic exercises. Currently, the injured worker complains of pain in the mid back, low back, down the left leg to the foot rated 10/10 intensity but reduced to an 8/10 with medications. The worker states his pain is decreased and his function is improved with the use of medication and without them he would have significant difficulty tolerating even routine activities of daily living. The IW was hospitalized on 02/10/2015 for acute withdrawal and dehydration. He has a pain contract. The request for authorization is for: Trazodone 100mg #30 with 3 refills; 10 Patches of Fentanyl 50 mcg/hr.; and Percocet 10/325mg #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazodone 100mg #30 with 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants Page(s): 13-14.

Decision rationale: This 59 year old male has complained of low back pain since date of injury 9/20/96. He has been treated with surgery, spinal cord stimulation, physical therapy and medications. The current request is for Trazadone. There is inadequate documentation in the available medical records regarding the use and efficacy of trazadone in this patient. Trazadone is approved for the treatment of depression. There is inadequate documentation of any subjective or objective findings of anxiety or depression in this patient. On the basis of this lack of medical documentation Trazadone is not indicated as medically necessary in this patient.

10 Patches of Fentanyl 50 mcg/hr: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Fentanyl Page(s): 47.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid, criteria for use Page(s): 76-85, 88-89.

Decision rationale: This 59 year old male has complained of low back pain since date of injury 9/20/96. He has been treated with surgery, spinal cord stimulation, physical therapy and medications to include opioids since at least 06/2014. The current request is for 10 patches of Fentanyl 50 mcg. No treating physician reports adequately assess the patient with respect to function, specific benefit, return to work, signs of abuse or treatment alternatives other than opioids. There is no evidence that the treating physician is prescribing opioids according to the MTUS section cited above which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, opioid contract and documentation of failure of prior non-opioid therapy. On the basis of this lack of documentation and failure to adhere to the MTUS guidelines, 10 patches of Fentanyl 50 mcg is not indicated as medically necessary.

Percocet 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78, 86-87, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid, criteria for use Page(s): 76-85, 88-89.

Decision rationale: This 59 year old male has complained of low back pain since date of injury 9/20/96. He has been treated with surgery, spinal cord stimulation, physical therapy and medications to include opioids since at least 06/2014. The current request is for Percocet 10/325.

No treating physician reports adequately assess the patient with respect to function, specific benefit, return to work, signs of abuse or treatment alternatives other than opioids. There is no evidence that the treating physician is prescribing opioids according to the MTUS section cited above which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, opioid contract and documentation of failure of prior non-opioid therapy. On the basis of this lack of documentation and failure to adhere to the MTUS guidelines, Percocet is not indicated as medically necessary.