

<b>Case Number:</b>	CM15-0097052		
<b>Date Assigned:</b>	05/28/2015	<b>Date of Injury:</b>	03/17/2010
<b>Decision Date:</b>	07/02/2015	<b>UR Denial Date:</b>	05/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/19/2015

### 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, 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 46-year-old male who sustained an industrial injury to his lower back on 03/23/2010. The injured worker was diagnosed with lumbar degenerative disc disease, lumbar radiculopathy and lumbar facet syndrome. Treatment to date includes diagnostic testing, conservative measures, lumbar epidural steroid injection, physical therapy, home exercise program and medications. According to the treating physician's progress report on April 20, 2015, the injured worker continues to experience low back pain with bilateral lower extremity pain and weakness. The injured worker rates his average pain level at 10/10 without medications and 6/10 with medications. Examination of the lumbar spine demonstrated tenderness to palpation at the paraspinal muscles with spasm and decreased range of motion in all planes and bilateral positive straight leg raise. There was decreased sensation to both lower extremities. Toe and heel walking was normal. Deep tendon reflexes were normal. Current medications are listed as Percocet, Soma, Tramadol, Trazodone, Lyrica, Medrol Pack and Lidoderm Patches. Treatment plan consists of medication regimen, moist heat, stretches, home exercise program and aerobic activity as tolerated, repeat lumbar epidural steroid injection, neurosurgical consultation, repeat lumbar magnetic resonance imaging (MRI), Functional Capacity Evaluation (FCE), urine drug screening and the current request for Percocet 10/325mg and Trazodone 50mg.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325mg #180: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16; 78-81. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 44, 47, 75-79, 120 of 127.

**Decision rationale:** Regarding the request for Percocet, California Pain Medical Treatment Guidelines state that this is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, while pain relief is noted, there is no indication that the medication is improving the patient's function (in terms of specific examples of functional improvement) and no specific discussion regarding aberrant use. Furthermore, it appears that the patient is concurrently utilizing multiple short-acting opioids, which is redundant. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Percocet is not medically necessary.

**Trazodone HCL 50mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16; 78-81. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Sleep Medication, Insomnia treatment.

**Decision rationale:** Regarding the request for trazodone, California MTUS guidelines are silent regarding the use of medication for sleep. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there is no current description of the patient's insomnia, no discussion regarding what behavioral treatments have been attempted, and no statement indicating how the patient has responded to treatment. Furthermore, there is no indication that trazodone is being used for short-term use as recommended by guidelines. In the absence of such documentation, the currently requested trazodone is not medically necessary.