

<b>Case Number:</b>	CM13-0053217		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	10/23/1998
<b>Decision Date:</b>	03/26/2014	<b>UR Denial Date:</b>	10/22/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/18/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 40-year-old female who reported an injury on 10/23/1998. The patient is diagnosed with reflex sympathetic dystrophy, unspecified neuralgia, neuritis, and radiculitis, pain in the joint in the forearm, pain in the thoracic spine, myalgia, myositis, osteoarthritis, cervicgia, lumbago, and long-term use of other medications. The patient was seen by [REDACTED] on 09/24/2013. The patient reported ongoing pain in the left lower extremity and right upper extremity. Physical examination revealed tenderness to palpation of the cervical spine, tenderness to palpation of the lumbar spine, decreased lumbar range of motion, decreased strength in the bilateral upper and lower extremities, decreased sensation in the C5-6 dermatomes bilaterally, and decreased sensation to light touch and vibration in the entire right upper extremity. Treatment recommendations included continuation of current medication including oxycodone, Lyrica, Skelaxin, Zofran, omeprazole, and trazodone.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Trazodone HCL 100mg tabs, 2 PO, QHS, PRN #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress Chapter, Trazodone (Desyrel).

**Decision rationale:** California MTUS Guidelines state antidepressants are recommended as a first-line option for neuropathic pain and as a possibility for non-neuropathic pain. Official Disability Guidelines state trazodone is recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. As per the documentation submitted, the patient has continuously utilized this medication. There is no documentation of any functional improvement as a result of the ongoing use of this medication. The patient does not maintain a diagnosis of insomnia, depression, or anxiety. The patient's mental status examination is within normal limits. The medical necessity for the requested medication has not been established. Therefore, the request is non-certified.