

<b>Case Number:</b>	CM13-0057913		
<b>Date Assigned:</b>	04/02/2014	<b>Date of Injury:</b>	02/22/2010
<b>Decision Date:</b>	07/02/2014	<b>UR Denial Date:</b>	11/21/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/26/2013

### 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. The expert reviewer is Board Certified in Orthopedic Surgery, has a subspecialty in Orthopedic Sports Medicine and is licensed to practice in Texas. 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/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 injured worker is a 55 year old male injured on 02/22/10 due to undisclosed mechanism of injury. Current diagnoses included chronic right shoulder pain due to impingement, low back pain due to chronic muscle tightness and strain, myofascial pain with underlying right chronic S1 radiculopathy. Clinical note dated 11/05/13 indicated the patient presented complaining of right shoulder and low back pain rated 6/10 with spasms in the low back. The patient reported increase numbness and tingling in the right arm and leg. The patient was participating in physical therapy which caused an increase in right shoulder pain resulting in insomnia and tiredness. There is reported depression as evidenced by symptoms of sadness, lack of interest and motivation during the day, and preference to stay inside the house, and lack of interaction. Physical examination revealed decreased range of motion of the right upper extremity. Norco decreased his pain level resulting in increased functionality. Trazodone was prescribed for insomnia due to pain. Medications included Trazodone 50mg, Effexor 75mg, Tramadol ER 150mg, Gabapentin 600mg, and Norco 10/325mg. The initial request for Trazodone 50mg #60, Effexor 75mg #60, Tramadol ER 150mg #30, and gabapentin 600mg #90 retrospective date of service was initially not recommended on 11/21/13.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TRAZODONE 50MG #60 RETROSPECTIVE DOS: 11/5/13: 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) Trazadone.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Trazodone (Desyrel).

**Decision rationale:** According to the Official Disability Guidelines (ODG), Trazodone is recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. It is also noted that there is limited evidence to support its use for insomnia, but it may be an option in patients with coexisting depression. As such, the request for Trazodone 50mg #60, retrospective DOS: 11/5/13 is medically necessary and appropriate.

**EFFEXOR 75MG #60 RETROSPECTIVE DOS: 11/5/13: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Effexor (venlafaxine) Page(s): 45.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines, Effexor is recommended as an option in first-line treatment of neuropathic pain. Additionally, it has FDA approval for treatment of depression and anxiety disorders. The employee has documented symptoms associated with depression indicating the need for pharmaceutical intervention. As such, the request for Effexor 75mg #60 retrospective DOS: 11/5/13 is medically necessary and appropriate.

**TRAMADOL ER 150MG #30 RETROSPECTIVE DOS: 11/5/13: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Opioids, criteria for use Page(s): 77.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. In this case, there is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. The clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics. Therefore, the request for Tramadol ER 150MG #30, retrospective DOS: 11/5/13 is not medically necessary and appropriate.

**GABAPENTIN 600MG #90 RETROSPECTIVE DOS: 11/5/13: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ANTI-EPILEPSY DRUGS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 49.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines, current guidelines recommend Gabapentin for the treatment of neuropathic pain. The clinical documentation establishes the presence of objective findings consistent with neuropathy. As such, the request for Gabapentin 600 mg #90, retrospective DOS: 11/5/13 is medically necessary and appropriate.