

Case Number:	CM14-0010218		
Date Assigned:	02/21/2014	Date of Injury:	12/15/2006
Decision Date:	06/25/2014	UR Denial Date:	01/08/2014
Priority:	Standard	Application Received:	01/24/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Ohio. 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 49-year-old female who reported an injury on 12/15/2006. The mechanism of injury was not provided. The clinical note dated 02/05/2014 reported the injured worker complained of low back pain with radiation to the lower extremities. She reportedly stated without medications the pain was rated 10/10 and with medications the pain was rated 8/10. The injured worker's medication regimen included Fentanyl, Dilaudid, Imitrex, Amitriptyline, Trazodone, Soma, Celexa, Seroquel, and Zanaflex. The clinical note also stated the injured worker's Amitriptyline along with Trazodone and Celexa helped with her depression. It was also noted the injured worker was ambulating with a cane. The diagnoses included status post coccyx fracture with coccyx removal in 2008, as well as failed spinal cord stimulator in 2008. The diagnoses also included depression and anxiety. The treatment plan included continuation of medications. The request for authorization was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRAZODONE 50 MG #60 (DATE OF SERVICE 11/6/2013): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ANTIDEPRESSANTS FOR CHRONIC PAIN,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Antidepressants, page(s) 13. Page(s): 13. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness and Stress, Trazadone.

Decision rationale: The request for Trazodone 50 mg #60 (date of service 11/06/2013) is not medically necessary. The injured worker has a history of low back pain treated with medication, physical therapy, and a (TENS) transcutaneous electrical nerve stimulation unit. The Chronic Pain Medical Treatment Guidelines, state antidepressants are recommended as a first-line option for neuropathic pain, and as a possibility for non-neuropathic pain. The Official Disability Guidelines recommended antidepressants for patients with depression, although, not generally as a stand-alone treatment. Antidepressants have been found to be useful in treating depression, including depression in physically ill patients. Within the clinical information provided for review, it is noted the injured worker's amitriptyline along with Trazodone help with depression along with her Celexa; however, there was a lack of documentation indicating an adequate assessment of the injured worker's psychological symptomatology occurred. The efficacy of the medication was unclear as evidenced by objective quantifiable improvement. Therefore, the request for Trazodone 50 mg #60 (date of service 11/06/2013) is not medically necessary.

CITALOPRAM 20 MG #60 (DATE OF SERVICE 11/6/2013): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ANTIDEPRESSANTS FOR CHRONIC PAIN,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Antidepressants for chronic pain, page(s) 16. Page(s).

Decision rationale: The request for Citalopram 20 mg #60 (date of service 11/06/2013) is not medically necessary. The injured worker has a history of low back pain radiating to her lower extremities treated with physical therapy, medications, and a TENS unit. The Chronic Pain Medical Treatment Guidelines, state it has been suggested that the main role of selective serotonin reuptake inhibitors (Citalopram) may be in addressing psychological symptoms associated with chronic pain. Within the clinical information provided for review it is noted the injured worker's amitriptyline along with Trazodone helps with depression, along with her Celexa; however, there was a lack of documentation indicating an adequate assessment of the injured worker's psychological symptomatology occurred. The efficacy of the medication was unclear as evidenced by objective quantifiable improvement. Therefore, the request for Citalopram 20 mg #60 (date of service 11/06/2013) is not medically necessary.