

<b>Case Number:</b>	CM14-0020627		
<b>Date Assigned:</b>	04/30/2014	<b>Date of Injury:</b>	10/28/2005
<b>Decision Date:</b>	07/08/2014	<b>UR Denial Date:</b>	01/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/19/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine, and is licensed to practice in Texas and Florida. 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 patient is a 41-year-old who was injured on October 28, 2005. The diagnoses listed are right knee pain, lumbar radiculopathy, cervical radiculopathy and neck pain. The patient completed the following interventional pain procedures; lumbar epidural steroid injections, cervical epidural steroid injections and nerve blocks with significant pain relief in 2009, 2010 and 2012. The MRI of the lumbar spine showed degenerative disc disease, neuroforaminal stenosis and facet degeneration. The past surgical history is significant for right knee surgery. There was history of GI (gastrointestinal) symptoms of heartburn, vomiting, burning pain and ulcer that is being treated with Prilosec. The medications listed are Norco, Ultram and Biofreeze for pain and trazodone for neuropathic pain and pain associated symptoms. A Utilization Review determination was rendered on January 31, 2014 recommending non-certification for retrospective January 9, 2014 prescription of trazodone 50mg #120 and retrospective January 9, 2014 prescription of Biofreeze #2.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **RETROSPECTIVE (1/09/2014) PRESCRIPTION OF TRAZODONE 50MG #120:**

Overtaken

**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 9792.20-9792.26 Page(s): 13-16.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines and ODG addressed the use of antidepressants in the management of chronic pain syndrome. Trazodone is an antidepressant that can be utilized for the treatment of insomnia, depression, anxiety and neuropathic pain syndrome. Analgesic effects usually occur within one week whereas antidepressant effects take longer to occur. Assessment of treatment efficacy should include pain outcome, ADL (activities of daily living) / physical function improvement, decrease in analgesic utilization and improvement of sleep quality and psychological status. This patient cannot tolerate NSAIDs (non-steroidal anti-inflammatory drugs) because of significant GERD (gastroesophageal reflux disease) symptoms. The record indicates that the patient is able to work part-time, do household chores and improve ADL because of significant pain relief from the use of the medications. The request for retrospective prescription of trazodone 50mg, 120 count, provided on January 9, 2014, is medically necessary and appropriate.

**RETROSPECTIVE (1/09/2014) PRESCRIPTION OF BIOFREEZE #2:** 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 9792.20-9792.26 Page(s): 56-57; 111-113.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines and the ODG addressed the use of topical analgesic preparations for the treatment of musculoskeletal and neuropathic pain. Biofreeze is a cryotherapy gel that can be used as an optional form of cryotherapy for acute pain. Biofreeze is a non-prescription topical cooling agent with menthol as the active ingredient that can be used in place of ice packs. There is no FDA approved indication for the use of topical menthol preparations in the treatment of chronic musculoskeletal pain. This patient did not have acute pain. He is suffering from chronic musculoskeletal pain since the 2005 injury. The request for retrospective prescription of biofreeze, quantity of two, provided on January 9, 2014, is not medically necessary or appropriate.