

<b>Case Number:</b>	CM14-0093545		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	11/23/2011
<b>Decision Date:</b>	09/30/2014	<b>UR Denial Date:</b>	06/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/19/2014

### 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 Occupational Medicine and is licensed to practice in Colorado. 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 worker sustained a right knee injury on 11/23/2011. The worker eventually also developed major depressive disorder, back pain, and left knee pain. An evaluation on 12/20/2013 documents anxiety with daily bearable nausea and burning upon urination starting after taking Effexor and Trazodone. There is a diagnosis of insomnia related to major depressive disorder and chronic pain. There is a report of feeling better, sleeping better with 6 hours on the weekends due to the need to get up early to go to work and 8-10 hours on weekends. On January 10, 2014 there is documentation of chronic lower back strain with left-sided sciatica but a non-diagnostic neurologic evaluation. There are ongoing knee complaints, but only on the left and low back symptoms. There were findings of tenderness of the lower back and crepitation of the knee but unclear whether right or left. Impressions included low back pain referred to the lower extremities, internal derangement of the right knee postoperative and internal derangement of the left knee. The worker was TENS unit and pain medications although no mention of the type or effects of the pain medications utilized. On 1/24/2014 there is documentation of feeling better, good restful sleep, improved depression symptomology and denial of side effects from Trazodone. There is a diagnosis of insomnia related to major depressive disorder. There is a treatment request for authorization includes Trazodone 50 mg p.o. q.h.s. #30. An evaluation on February 13, 2014 documents constant left knee pain, pain affecting sleep waking him up at night, being prescribed Trazodone for insomnia and Effexor for depression, a discontinuation of anti-inflammatory medication 3 days prior to the surgery. There is a pre-surgical evaluation on February 18, 2014 documenting medications as follows: "An NSAID", omeprazole, Flexeril, "another pain medication". There is documentation of a newly discovered inguinal hernia this should be dealt with before knee surgery. On February 21, 2014 a progress report documents good restful sleep, denied depressed mood, feeling better, and the use of Effexor and Trazodone.

Diagnoses include major depressive disorder, single episode, partial remission, insomnia related to major depressive disorder, chronic pain. Treatment plan includes Effexor, Trazodone (25 p.o. q.h.s. decreased from 50 p.o. q.h.s., #30), and cognitive behavioral therapy for chronic pain. An evaluation on 4/22/2014 documents no issues with sleep (review of systems section). Medication progression described as "same as the last time" to include Naproxen 550 or 60, Tramadol extended release 150 #30, Protonic 20 mg, Effexor, and Trazodone 50 mg #60. Examination on 5/2/2014 documents good sleep, considered psychologically permanent and stationary, and released from psychological care. There is a recommendation to continue psychopharmacological treatment with antidepressant medication Effexor prescribed by primary treating physician. On May 8, 2014 is documentation of pain that wakes the worker up at night also affecting mood. There is documentation of being on Effexor. There is documentation of being seen by psychiatry for depression and insomnia. There is an instruction to discontinue naproxen 3 days prior to the surgery. There is a description of being treated by psychiatry for depression and insomnia with current use of Effexor for depression and Trazodone for insomnia. There is a distribution of Tramadol ER 150 mg #30, Naproxen 500 mg #60, Protonic, Flexeril, Effexor, and Topamax for neuropathic pain. An evaluation on May 22, 2014 documents continued issues with sleep (review of systems section), stress and depression. No medications are needed.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Trazodone 15mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-16. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Clinical practice guidelines for the management of patients with insomnia in primary care. Madrid (Spain): Health Technology Assessment Unit, Lain Entralgo Agency, Ministry of Health, Social Services and Equality (Spain); 2009. 159 p. [207 references].

**Decision rationale:** The MTUS provides a description of benzodiazepine (i.e. Trazodone) use where it states that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. The MTUS also states that most guidelines limit use to 4 weeks. It also states that chronic benzodiazepines are the treatment of choice for very few conditions and that tolerance to hypnotic effects develops rapidly. According to the Clinical Practice Guidelines For The Management Of Patients With Insomnia In Primary Care, regarding hypnotics (benzodiazepines) used for treating insomnia, it is recommended that treatment is short-term (not more than 4 weeks) and at the lowest possible dose. Long-term use of hypnotics is not recommended and if doing so, she does be monitored with a diagnosis in any specific regimen. To prevent dependence on benzodiazepines, their use should be restricted to acute insomnia, at the lowest dose possible and for no longer than 2-4 weeks. There is documentation that the worker was diagnosed as having had insomnia secondary to major

depressive disorder on 12/20/13 with persistent symptoms of depression. Subsequent medical records document disrupted sleep secondary to pain without continued correlation of sleep disturbance to major depressive disorder. The MTUS Chronic Pain Medical Treatment Guideline, as well as the referenced alternate guideline\* (above), endorse short term use only of benzodiazepines when treating insomnia. The records document that the duration of use of Trazodone has substantially exceeded 4 weeks. Therefore, the request for Trazodone is not considered medically necessary or appropriate.

**Tramadol ER 150mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain interventions and treatments Page(s): 75, 77, 78, 81, 82.

**Decision rationale:** Tramadol is a centrally acting analgesic and is considered a fourth class opiate. The MTUS suggests that opioids appear to be efficacious for the treatment of chronic pain but should be limited for short-term pain relief. The long-term efficacy of opioids is currently unclear and appears to be limited. A failure to respond to a time-limited course of an opiate should lead to a reassessment and consideration of alternative therapy. The MTUS cites three studies comparing it to placebo with reported pain relief but no improved function. According to the MTUS, if there is no overall improvement in function from opioid use, the medication should be discontinued. The available records do not document an improvement in either pain or function secondary to Tramadol use and therefore, the request for Tramadol is not recommended as medically necessary or appropriate.

**Naproxen 550 #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroid anti-inflammatory drugs Page(s): 67-68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain interventions and treatments Page(s): 60.

**Decision rationale:** The MTUS chronic medical treatment guidelines state that relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. The MTUS states that for analgesic medications, a record of pain and function with the medication should be recorded. There is no documented improvement in pain and function attributable to Naprosyn use and therefore, the request for Naprosyn is not considered medically necessary or appropriate.