

Case Number:	CM14-0056798		
Date Assigned:	07/09/2014	Date of Injury:	08/01/1993
Decision Date:	04/10/2015	UR Denial Date:	04/11/2014
Priority:	Standard	Application Received:	04/28/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Georgia, California, Texas

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 53 year old male with an industrial injury dated 08/01/1993. He presents for follow up on 03/12/2014 complaining of carpal tunnel symptoms bothering him again. Cervical epidural steroid injection on 01/30/2014 provided about 60% relief to neck, upper extremities and headache symptoms. He also states 50% relief from lumbar epidural steroid injection done on 10/07/2013. He rated his pain as 4/10. Physical exam revealed tenderness of the cervical spine with decreased range of motion. Upper extremities revealed decreased sensation with wartenberg pinwheel along the lateral arm and forearm bilaterally. Lumbar spine revealed tenderness and limited range of motion. Prior treatments included cervical steroid injection, lumbar epidural steroid injection, and Synvisc injections to right knee, cortisone injections to right knee, trigger point injections and medications. Electro diagnostic study of bilateral lower extremities on 09/10/2013 showed moderate to severe lumbar 5 radiculopathy. Other diagnostic studies are documented in the 03/12/2014 note. Diagnosis: Cervical degenerative disc disease with facet arthropathy and bilateral upper extremity radiculopathy- Lumbar degenerative disc disease with facet arthropathy and foraminal narrowing with associated bilateral lower extremity radiculopathy, Bilateral knee internal derangement, Reactionary depression, Non-insulin dependent diabetes mellitus, Bilateral ulnar nerve entrapment. On 04/11/2014 utilization review issued the following decision: The request for Trazodone 150 mg # 30 was partially certified for Trazadone 150 mg # 15. The request for Lexapro 10 mg # 30 was partially certified for Lexapro 10 mg # 15. The request for Zanaflex 4 mg # 60 was partially certified for Zanaflex 4 mg # 30. ODG and MTUS were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazodone 150 MG #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-16 of 127. Decision based on Non-MTUS Citation ODG Pain Chapter, Insomnia treatment.

Decision rationale: MTUS recommends use of antidepressants "...as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain." ODG also notes that trazodone is useful for treatment of insomnia for chronic pain patients with depression. Office notes document a history of neuropathic pain and reactive depression and anxiety in this case. Based upon the submitted clinical information and MTUS recommendations, medical necessity is established for the requested trazodone.

Lexapro 10 MG #30: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-16 of 127. Decision based on Non-MTUS Citation ODG Pain Chapter, Anxiety medications in chronic pain.

Decision rationale: MTUS recommends use of antidepressants "...as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain." Office notes document history of chronic pain and reactive depression and anxiety. In addition to its use for depression, ODG recommends SSRI antidepressants including Lexapro as first-line treatment for anxiety. The requested Lexapro is reasonable and medically necessary.

Zanaflex 4 MG #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Weaning of Medications Page(s): 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63 and 66 of 127.

Decision rationale: MTUS notes evidence for the effectiveness of off-label use of tizanidine (Zanaflex) for treatment of chronic low back pain, per multiple studies. ODG also notes evidence for effectiveness of tizanidine for myofascial pain. Based upon the clinical information

supplied and MTUS recommendations, the requested tizanidine is reasonable and medically necessary.