

<b>Case Number:</b>	CM15-0102202		
<b>Date Assigned:</b>	06/04/2015	<b>Date of Injury:</b>	12/13/2011
<b>Decision Date:</b>	07/07/2015	<b>UR Denial Date:</b>	05/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/27/2015

### 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: California

Certification(s)/Specialty: Emergency 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 35-year-old male who sustained an industrial injury on 12/13/11. The injured worker was diagnosed as having right ulnar nerve injury with claw hand deformity and insomnia. Currently, the injured worker was with complaints of right hand pain. Previous treatments included medication management. Previous diagnostic studies included a magnetic resonance imaging (July 2014) which was unremarkable. The injured workers pain level was noted as 7/10 with medication and 9/10 without medication. Physical examination was notable for right wrist restricted range of motion and tenderness to palpation over the ulnar side. The plan of care was for medication prescriptions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Trazodone 50mg #30 with 2 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain Page(s): 13-15.

**Decision rationale:** The requested Trazodone 50mg #30 with 2 refills is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Antidepressants for Chronic Pain, Pages 13-15, recommend SSRI antidepressants as a second option for the treatment of depression, and even though they are not recommended for the treatment of chronic pain, they are recommended for the treatment of neuropathic pain. "Tricyclic antidepressants are recommended over selective serotonin reuptake inhibitors, unless adverse reactions are a problem." The treating physician has documented right wrist restricted range of motion and tenderness to palpation over the ulnar side. The treating physician has not documented failed trials of tricyclic antidepressants, nor objective evidence of derived functional improvement from previous use. The criteria noted above not having been met, Trazodone 50mg #30 with 2 refills is not medically necessary.