

<b>Case Number:</b>	CM15-0137466		
<b>Date Assigned:</b>	07/27/2015	<b>Date of Injury:</b>	02/24/2003
<b>Decision Date:</b>	08/31/2015	<b>UR Denial Date:</b>	06/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/15/2015

### 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 59-year-old female who sustained an industrial injury on 02/24/2003. Mechanism of injury was not found in documentation provided. Diagnoses include back pain, and lumbar radiculopathy. Treatment to date has included diagnostic studies, medications, activity modification, physical therapy, and she is status post lumbar spine surgery. Her medications include Percocet, Provigil, Butrans patch, and Tizanidine. A physician progress note dated 05/29/2015 documents the injured worker complains of low back pain that radiates into both lower extremities. Her pain is moderate. Symptoms are described as aching and the pain is constant. She rates her pain as 3 out of 10. She has tapered herself down from 4 Percocet a day to only 1 or 2 a day. Her pain is worse with this decrease but she continues to function thanks to her Butrans patch. There is tenderness to palpation at the lower spine. Range of motion is restricted. Kemps test is positive on the right and left. Examination revealed tenderness, and decreased range of motion. There is a positive Kemp's test. Treatment requested is for Trazodone 50 Mg #30 1 tab q hour of sleep.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Trazodone 50 Mg #30 1 TAB PO QHS: 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 Antidepressants for Chronic Pain, Pages 13-15 Page(s): 13-15.

**Decision rationale:** The requested Trazodone 50 Mg #30 1 TAB PO QHS, 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 injured worker has low back pain that radiates into both lower extremities. Her pain is moderate. Symptoms are described as aching and the pain is constant. She rates her pain as 3 out of 10. She has tapered herself down from 4 Percocet a day to only 1 or 2 a day. Her pain is worse with this decrease but she continues to function thanks to her Butrans patch. There is tenderness to palpation at the lower spine. Range of motion is restricted. Kemps test is positive on the right and left. Examination revealed tenderness, and decreased range of motion. There is a positive Kemp's test. 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 50 Mg #30 1 TAB PO QHS is not medically necessary.