

<b>Case Number:</b>	CM15-0021615		
<b>Date Assigned:</b>	02/11/2015	<b>Date of Injury:</b>	09/01/2007
<b>Decision Date:</b>	04/03/2015	<b>UR Denial Date:</b>	01/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/04/2015

### 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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 50-year-old male who reported an injury on 09/01/2007. The specific mechanism of injury was not provided. The prior treatments included medication, physical therapy, and acupuncture. The injured worker underwent an MRI of the right knee. The injured worker was noted to be utilizing antidepressants and NSAIDs as of 2012. The injured worker utilized a TENS unit and a brace. The injured worker was noted to have surgery on his right knee. There was a Request for Authorization submitted for the medications dated 01/16/2015. The documentation of 01/15/2015 revealed the injured worker had pain in the back right knee and bilateral hands. The injured worker had cortisone injections followed by Hyalgan injections for the right knee. The injured worker was noted to have rigid braces for the bilateral hands. The physical examination revealed the injured worker had tenderness along the paraspinal musculature. The standing x-rays showed a 1 mm of articular surface left on the right knee. The diagnoses included internal derangement of the knee on the right status post surgery and discogenic lumbar condition, as well as wrist joint inflammation bilaterally. The treatment plan included the injured worker was to have a ten panel drug screen, CBC, and comprehensive metabolic panel and a request was made for trazodone 50 mg #60 and Nalfon 400 mg #60.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 prescription of Trazodone HCL 50mg #60: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Pain (Chronic).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines antidepressants Page(s): 13.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines recommend antidepressants as a first line medication for treatment of neuropathic pain and they are recommended especially if pain is accompanied by insomnia, anxiety, or depression. There should be documentation of an objective decrease in pain and objective functional improvement to include an assessment in the changes in the use of other analgesic medications, sleep quality and duration and psychological assessments. The clinical documentation submitted for review indicated the injured worker had utilized the medication since at least 2012. There was a lack of documentation of an objective decrease in pain and an objective functional improvement to include an assessment in the changes of the use of other analgesic medications, sleep quality and duration, and psychological assessments. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for 1 prescription of trazodone HCL 50mg #60 is not medically necessary.

**1 prescription of Nalfon 400mg #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines indicate that NSAIDS are recommended for short term symptomatic relief of low back pain. It is generally recommended that the lowest effective dose be used for all NSAIDS for the shortest duration of time consistent with the individual patient treatment goals. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review failed to provide documentation of objective functional improvement and an objective decrease in pain. The documentation indicated the injured worker had utilized this classification of medication since at least 2012. There was a lack of documentation of exceptional factors as the medication is to be utilized for a short time only. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for 1 prescription of Nalfon 400mg #60 is not medically necessary.