

<b>Case Number:</b>	CM15-0031908		
<b>Date Assigned:</b>	02/25/2015	<b>Date of Injury:</b>	12/01/2010
<b>Decision Date:</b>	04/06/2015	<b>UR Denial Date:</b>	01/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/20/2015

### 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, Indiana, New York  
 Certification(s)/Specialty: Internal 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 55 year old male, who sustained an industrial injury on 12/1/10. He has reported rib and shoulder injury. The diagnoses have included low back pain, upper back pain, shoulder pain and neck pain. Treatment to date has included lumbar transforaminal epidural injection at L3-4 level, physical therapy and oral medication management. Currently, the injured worker complains of low back pain, upper back pain, shoulder pain and neck pain. Physical exam dated 12-3/14 noted pain over bilateral superior medial trapezius with palpation and pain over left and right lumbar paraspinal muscles with palpation. On 1/23/15 Utilization Review non-certified Trazodone 50mg #30, noting it appears unwarranted as the injured worker has been treated with this medication for 2 years and reports do not note any sleep problems or diagnosed depression and Cyclobenzaprine 10mg #30, noting the use of it may be inappropriate and incongruent with recommendations. The MTUS, ACOEM Guidelines, was cited. On 2/20/15, the injured worker submitted an application for IMR for review of Trazodone 50mg #30 and Cyclobenzaprine 10mg #30.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 prescription of Trazodone 50mg #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 388.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental illness and stress section, Trazodone.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Trazodone 50 mg #30 is not medically necessary. Trazodone is recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. See the guidelines for additional details. In this case, the injured worker's working diagnoses are lumbosacral neuritis; brachial neuritis; enthesopathy of hip. The injured worker's medication list includes Morphine sulfate extended release 15 mg; Percocet 10/325 mg; Flexeril 7.5 mg; trazodone 50 mg; and lorazepam 1 mg. The documentation states the injured worker has trouble sleeping. There is no documentation containing mild psychiatric symptoms such as depression or anxiety. Consequently, absent clinical documentation coexisting mild psychiatric symptoms such as depression and anxiety, Trazodone 50 mg #30 is not medically necessary.

**1 prescription of Cyclobenzaprine 10mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental Illness & Stress.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Muscle relaxants.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Flexeril 7.5 mg #30 is not medically necessary. Muscle relaxants are recommended as a second line option short-term (less than two weeks) of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Efficacy appears to diminish over time and prolonged use may lead to dependence. In this case, the injured worker's working diagnoses are lumbosacral neuritis; brachial neuritis; enthesopathy of hip. The documentation shows the injured worker was taking Flexeril 7.5 mg as far back as April 30, 2014. The injured worker's medication list includes Morphine sulfate extended release 15 mg; Percocet 10/325 mg; Flexeril 7.5 mg; Trazodone 50 mg; and Lorazepam 1 mg. Flexeril is indicated for short-term use (less than two weeks) treatment of acute low back pain or an acute exacerbation in patients with chronic low back pain. There is no documentation of an acute exacerbation of back pain record. Moreover, the treating physician has exceeded the recommended guidelines for short-term use (less than two weeks) by continuing Flexeril from April 2014 through February 2015 (approximately 10 months). Consequently, absent clinical documentation with objective functional improvement in excess of the recommended guidelines, Flexeril 7.5 mg #30 is not medically necessary.

