

<b>Case Number:</b>	CM15-0051302		
<b>Date Assigned:</b>	03/24/2015	<b>Date of Injury:</b>	01/31/2003
<b>Decision Date:</b>	05/05/2015	<b>UR Denial Date:</b>	03/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/18/2015

### 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: Arizona, Texas  
 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 47 year old female who sustained an industrial injury to her right shoulder and neck on January 31, 2003. The injured worker was diagnosed with discogenic cervical condition, impingement syndrome of the right shoulder and headaches. The injured worker is status post right shoulder biceps tendon release, decompression, tenolysis and manipulation in 2007 and 2008. The most recent magnetic resonance imaging (MRI) of the right shoulder was performed in 2014, cervical magnetic resonance imaging (MRI) and Nerve Conduction Velocity (NCV) in 2009. Treatment to date has included physical therapy, chiropractic therapy (12 sessions), epidural steroid injections (ESI), hot/cold wraps, cervical pillow, cervical traction with air bladder, and transcutaneous electrical nerve stimulation (TEN's) unit. According to the primary treating physician's progress report on February 4, 2015, the patient continues to experience tenderness along the biceps tendon and rotator cuff with positive impingement signs. Range of motion of the neck is limited with mild facet discomfort. Current medications are listed as Neurontin, Trazodone, Tylenol #4, Flexeril, Tramadol ER, Wellbutrin, Lunesta and Prilosec. Treatment plan consists of avoiding medications with ibuprofen and the requested authorization for Trazodone, Lunesta as well as transcutaneous electrical nerve stimulation (TEN's) pads.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Transcutaneous electrical nerve stimulation (TENS) pads for next (refill): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-.26 Page(s): 114-117.

**Decision rationale:** According to the MTUS, the use of a transcutaneous electrical nerve stimulation (TENS) is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. These conditions include neuropathic pain, Phantom limb pain and CRPSII, spasticity, and multiple sclerosis. In this case the patient is not enrolled in an evidence-based functional restoration program and doesn't have an accepted diagnosis per the MTUS. The continued use of TENS unit and therefore the pads are not medically necessary.

**Trazodone 50mg qty: 60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for pain Page(s): 13-16. Decision based on Non-MTUS Citation ODG Pain Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation UpToDate.com. Drug information.

**Decision rationale:** The MTUS is silent regarding the use of trazodone. Trazodone is an antidepressant, Serotonin Reuptake Inhibitor/Antagonist FDA approved for the use of depression. An off-label use is for insomnia. For the treatment of depression the dose is 150 mg daily in divided doses (may increase by 50 mg daily every 3 to 4 days); once daily doses at bedtime may be considered to minimize adverse effects (Haria,1994; Rawls,1982); maximum dose: 600 mg daily. Monitoring parameters are baseline liver function prior to and periodically during therapy; suicide ideation (especially at the beginning of therapy or when doses are increased or decreased); signs/symptoms of serotonin syndrome. In this case the current dose is not a recommended dose for treatment of depression and the documentation doesn't show that the medication is being properly monitored. Therefore the request is not medically necessary.

**Lunesta 2mg qty: 30: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG - Pain; [www.odgtreatment.com](http://www.odgtreatment.com); [www.worklossdata.com](http://www.worklossdata.com) (updated 02/14/12).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation UptoDate.com. Drug information. Treatment of Insomnia.

**Decision rationale:** The MTUS is silent regarding the use of lunesta for chronic insomnia. The FDA has approved the use of Lunesta treatment of insomnia (with difficulty of sleep onset). When treating insomnia all patients should receive therapy for any medical condition, psychiatric illness, substance abuse or sleep disorder that may be precipitating or exacerbating the insomnia. For patients who continue to have insomnia that is severe enough to require intervention cognitive behavioral therapy (CBT) is the initial therapy that is recommended. If a patient requires a combination of behavioral therapy and medication a short acting medication is recommended for 6-8 weeks and then tapered. If the patient is still having symptoms they may require evaluation in a sleep disorder center prior to the institution of long-term medications. In this case the documentation doesn't support that the patient has been evaluated for insomnia with CBT or evaluation of medical or psychiatric illness. The continued use of lunesta is not medically necessary.