

<b>Case Number:</b>	CM15-0057600		
<b>Date Assigned:</b>	04/02/2015	<b>Date of Injury:</b>	08/27/2008
<b>Decision Date:</b>	05/05/2015	<b>UR Denial Date:</b>	03/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/26/2015

### 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: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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:

This 29-year-old male sustained work related industrial injuries on August 27, 2008. The injured worker diagnoses include compression injury to right wrist and status post arthroscopic and open ligament repairs. Treatment consisted of diagnostic studies, prescribed medications, and periodic follow up visits. Per treating provider report dated 02/26/2015, the injured worker reported constant pain on the ulnar aspect of his right wrist and pain related sleep disorder. Objective findings revealed decrease grip strength and tenderness to palpitation in wrist and hand on the right side. The treating physician also noted multiple healing scars on the right wrist and limited flexion on the right wrist. The treating physician prescribed services for Lyrica, Celebrex, and Trazadone now under review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lyrica 200mg TID #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16, 19.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lyrica Page(s): 20.

**Decision rationale:** According to MTUS guidelines, “Lyrica is an anti-epilepsy drug (AEDs - also referred to as anti-convulsant), which has been shown to be effective for treatment of diabetic; painful neuropathy and post-therapeutic neuralgia; and has been considered as a first-line treatment for neuropathic pain.” There is no clear documentation of neuropathic pain in this patient that required and responded to previous use of Lyrica. Therefore, the request for Lyrica 200mg #90 is not medically necessary.

**Celebrex 200mg Q 12 hrs #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 30, 67-69.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti inflammatory medications Page(s): 27-30.

**Decision rationale:** According to MTUS guidelines, Celebrex is indicated in case of back, neck and shoulder pain especially in case of failure or contraindication of NSAIDs. There is no clear documentation that the patient failed previous use of NSAIDs. There is no documentation of contra indication of other NSAIDs. There is no documentation that Celebrex was used for the shortest period and the lowest dose. The patient continued to report chronic pain. Therefore, the prescription of Celebrex 200mg #60 is not medically necessary.

**Trazodone 50mg 1-2 at hs #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 (ODG), Mental illness and Stress.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Schwartz, T., et al. (2004). ""A comparison of the effectiveness of two hypnotic agents for the treatment of insomnia"." Int J Psychiatr Nurs Res 10(1): 1146-1150.

**Decision rationale:** There is no clear evidence that the patient was diagnosed with major depression requiring Trazodone. There is no formal psychiatric evaluation documenting the diagnosis of depression requiring treatment with Trazodone. In addition, there is no recent documentation of insomnia. There is no documentation of failure of first line treatments for insomnia and depression. Therefore, the request for Trazodone 50mg #60 is not medically necessary.