

<b>Case Number:</b>	CM15-0084473		
<b>Date Assigned:</b>	05/06/2015	<b>Date of Injury:</b>	06/05/2013
<b>Decision Date:</b>	06/05/2015	<b>UR Denial Date:</b>	04/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/01/2015

### 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: North Carolina, Georgia  
 Certification(s)/Specialty: Family Practice

### 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 53 year old female, who sustained an industrial injury on 6/5/03. She has reported initial complaints of back pain after repetitive bending. The diagnoses have included lumbago, chronic pain syndrome, lumbar degenerative disc disease (DDD), chronic insomnia, depression, obesity and anxiety. Treatment to date has included medications, physical therapy, work modifications, activity modifications, and conservative care. Currently, as per the physician progress note dated 4/8/15, the injured worker complains of low back pain with radicular complaints down both legs. She reports poor pain control with OxyContin and Percocet. The pain is located in the bilateral legs, bilateral buttocks, neck thoracic spine and bilateral low back. In the last month with medications, the injured worker states that the least pain is 5/10 on pain scale, the average pain is 6/10 and the worst pain is 9/10. The least pain has increased since last visit. The current medications included OxyContin, Percocet, Gabapentin, Trazadone, Lidoderm patch, Colace and Voltaren. The urine drug screen dated 8/27/14 was inconsistent with medications prescribed. There were no recent diagnostic studies noted. The physical exam revealed obese female that uses a four wheeled walker to ambulate. The lumbar spine reveals limited range of motion. Treatment plan was for medication re-fills. The physician requested treatments included Trazodone HCL 50mg, #30 with 4 refills; Lidoderm patches 5%, #30 with 4 refills and Three (3) tubes of Voltaren Gel 1% with 4 refills.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Trazodone HCL 50mg, #30 with 4 refills: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 11th Edition (web), 2014, Mental Health and Stress, Trazodone (Dysyrel).

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

**Decision rationale:** CA MTUS is silent on the use of trazodone. ODG addresses its use in the section on Mental/Stress. Trazodone is recommended as a second line treatment for use for insomnia with concurrent mild depression or anxiety. There is no clear cut evidence to recommend it as first line treatment for insomnia. It is used off label for alcoholism, anxiety and panic disorder. It is generally not used for major depressive disorder. In this case, the claimant does have diagnoses of insomnia, anxiety and depression but there is no other documented prior treatment of insomnia, behavioral or pharmacologic, and no clear documentation of response to treatment with Trazodone. The initial UR decision approved a 30 day supply of trazodone with the recommendation of submission of documentation of response to treatment to assess need for ongoing therapy. The request for trazodone 50 mg #30 with 4 refills is not medically indicated and the original UR decision is upheld.

**Lidoderm patches 5%, #30 with 4 refills: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants for chronic pain Page(s): 13-14.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section 2 Page(s): 56-57.

**Decision rationale:** The CA MTUS states that topical lidocaine preparations such as Lidoderm may be used as second line treatment for localized peripheral pain after a first line treatment, such as tricyclic antidepressant, SNRI or AED, has tried and failed. The medical records in this case do describe any prior treatment with a first line treatment which inadequately controlled pain and therefore the use of Lidoderm is medically necessary.

**Three (3) tubes of Voltaren Gel 1% with 4 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics; Voltaren Gel 1% (Diclofenac) Page(s): 111-112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section 2 Page(s): 111-113.

**Decision rationale:** CA MTUS recommends limited use of topical analgesics. There is limited evidence for short-term use of topical NSAID analgesics for osteoarthritis with most benefit seen in use up to 12 weeks but no demonstrated benefit beyond this time period. Voltaren gel is recommended for treatment of osteoarthritis in joints for which lend themselves to topical treatment such as ankle, knee, elbow, wrist, hand and foot. It is not studied for use on spine, hip and shoulder. Voltaren gel for application to lumbar spine is not medically necessary.