

<b>Case Number:</b>	CM14-0135939		
<b>Date Assigned:</b>	09/03/2014	<b>Date of Injury:</b>	10/07/2005
<b>Decision Date:</b>	10/31/2014	<b>UR Denial Date:</b>	07/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/22/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 49-year-old male who was reportedly injured on 10/07/2005. The mechanism of injury was noted as a fall. The most recent progress note dated 7/17/14, indicated that the injured worker reported feeling worse. There were ongoing complaints of right shoulder pain. Increased dizziness was also reported. The operative note mentioned severe glenoid degeneration and SLAP lesion, debridement and labral repair was done. Pain was reported to be dull and constant, 8-9/10, and worse on movement, and improved with medication. Orthopedic note dated 7/18/2014 reported that upon physical examination no acute distress was noted. The injured worker was noted to be guarding the right shoulder, incisions were found to be clean, dry and intact. Passive range of motions to abduction to 70, forward flexion of 80 and external rotation of 10 degrees and internal to S1 were reported. Positive Hawkins and positive empty can was reported. Previous treatment included right shoulder arthroscopy on 7/7/14, medications, and conservative treatment. A request was made for trazodone 50-100 mg #100 and promethazine 25 mg #30 and was not certified in the pre-authorization process on 07/24/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TRAZODONE 50-100MG #100:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) - Chronic Pain - Clinical Measures - Medications: Antidepressants (electronically cited)

**Decision rationale:** Trazodone (Desyrel) is an antidepressant of the serotonin antagonists and reuptake inhibitor (SARI) with anti-anxiety and sleep-inducing effects. MTUS/ACOEM practice guidelines do not support trazodone for treatment of chronic persistent pain without depression. Review of the available medical records fails to document a diagnosis of depression. As such, this request is not considered medically necessary.

**PROMETHAZINE 25MG #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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain (Chronic). Promethazine. Updated 10/6/2014

**Decision rationale:** According to ODG guidelines, promethazine is not recommended for nausea and vomiting secondary to chronic opioid use. After review of the medical documentation provided, there was no identifiable determination of any other justification for the continued use of this medication. Therefore, this request is deemed not medically necessary.