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| Case Number: | CM14-0146366 | | |
| Date Assigned: | 09/12/2014 | Date of Injury: | 05/15/2004 |
| Decision Date: | 10/14/2014 | UR Denial Date: | 08/20/2014 |
| Priority: | Standard | Application Received: | 09/09/2014 |

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 Internal Medicine 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 57-year-old male who reported an injury on 05/15/2010. He was standing at the top of a ramp, spotting a forklift driver who was bringing down a piece of equipment, when the equipment started to tip off the forklift. The injured worker ran down the ramp to try to hold the piece of equipment from falling, but he slipped and fell. He sustained injuries to his neck, left hip, and back. The injured worker's treatment history included x-rays, acupuncture sessions, aquatic therapy, magnetic resonance imaging studies, epidural steroid injections, medications, and physical therapy. The injured worker was evaluated on 08/21/2014, and it was documented the injured worker complained of chronic, severe pain at multiple sites. He had chronic severe right knee pain due to osteoarthritis. He also had chronic, severe, cervicgia and intermittent cervical radiculopathy due to cervical degenerative disease, as well as MPS. He also had chronic severe LPB and intermittent lumbar radicular pain due to failed back surgery syndrome following lumbar fusion in 04/2007. The injured worker does not take any NSAIDs. He is on Gabapentin, which provides wonderful pain relief, improves sleep and functional improvement; refuses Cymbalta. He takes Senokot S for constipation, Elavil for insomnia and pain, and Flexeril for spasms in the legs. The injured worker also was taking Trazodone for insomnia, per his psychiatrist. He received 50% index pain relief and functional improvement with decreased medication requirements lasting greater than 6 weeks from the last right knee intra-articular injection on 05/04/2012. Pain score was 9/10 without medications, and with medications, it was 5/10. A physical examination of the lumbar and sacral spine revealed tenderness to palpation over the paraspinals. Forward flexion was 35 degrees, hyperextension was 20 degrees, and right/left lateral bend was 15 degrees. Squatting was abnormal. Sciatic notch tenderness was present bilaterally. Sitting straight leg raise right/left was positive. Toe walking and heel walking was abnormal. Fabere test was positive. There was decreased right upper

extremity in a predominantly C7 nerve root distribution pattern. The medications included OxyContin 30 mg, Norco 10/325 mg, Flexeril 5 mg, Senokot S 8.6/50 mg, Trazodone HCl 50 mg, Neurontin 600 mg, Losartan potassium tabs, and Nabumetone 500 mg. Diagnoses included anxiety, muscle spasm, brachial neuritis or radiculitis NOS, lumbosacral spondylosis without myelopathy, cervical spondylosis without myelopathy, postlaminectomy syndrome lumbar region, degeneration of cervical intervertebral disc, cervicalgia, spinal stenosis in cervical region, and lumbago. The Request for Authorization 08/08/2014 was for Trazodone 100mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazodone 100mg #30 with 3 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, Mental Illness and Stress, Insomnia Treatment

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Antidepressants for Chronic Pain, Page(s): 14 & 15.

Decision rationale: The requested is not medically necessary. California (MTUS) Chronic Pain Medical Guidelines recommends Trazodone as a selective serotonin and norepinephrine reuptake inhibitors (SNRIs) and FDA-approved for anxiety, depression, diabetic neuropathy, and Fibromyalgia. Duloxetine is recommended as a first-line option for diabetic neuropathy. No high quality evidence is reported to support the use of Duloxetine for lumbar radiculopathy. A systematic review indicated that tricyclic antidepressants have demonstrated a small to moderate effect on chronic low back pain (short-term pain relief), but the effect on function is unclear. This effect appeared to be based on inhibition of norepinephrine reuptake. SSRIs have not been shown to be effective for low back pain (there was not a significant difference between SSRIs and placebo) and SNRIs have not been evaluated for this condition. Reviews that have studied the treatment of low back pain with tricyclic antidepressants found them to be slightly more effective than placebo for the relief of pain. A non-statistically significant improvement was also noted in improvement of functioning. SSRIs do not appear to be beneficial. It is recommended that these outcome measurements should be initiated at one week of treatment with a recommended trial of at least 4 weeks. The documents submitted failed to indicate the injured worker's outcome measurements while taking Trazodone. Furthermore, the documents submitted failed to indicate the outcome measurements of home exercise regimen and pain medication management. The request submitted failed to include duration and frequency of medication. As such the request for Trazodone 100 mg #30 with 3 refills is not medically necessary.