

<b>Case Number:</b>	CM14-0181513		
<b>Date Assigned:</b>	11/06/2014	<b>Date of Injury:</b>	05/06/2010
<b>Decision Date:</b>	12/19/2014	<b>UR Denial Date:</b>	10/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/31/2014

### 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 Pennsylvania. 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 59-year-old gentleman with a date of injury of 05/06/2010. The submitted and reviewed documentation did not identify the mechanism of injury. Treating physician notes dated 06/10/2014 and 09/09/2014 indicated the worker was experiencing pain in the neck and right shoulder, numbness and tingling in the neck and arm, and problems sleeping. The examinations documented by the note dated 09/09/2014 described decreased motion in the right shoulder joint and weak grip with both hands; the note dated 06/10/2014 did not record an examination. The submitted and reviewed documentation concluded the worker was suffering from carpal tunnel syndrome involving wrists, neck pain, and right shoulder pain. Treatment recommendations included oral pain medications, medication to improve sleep, cold therapy with Biofreeze gel, and follow up care. A Utilization Review decision was rendered on 10/17/2014 recommending non-certification for 120 tablets of trazodone 50mg and for two containers of Biofreeze gel.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Trazodone 50mg. QTY: 120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain Page(s): 13-16. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Trazodone: Drug information. Topic 10013, version 119.0. UpToDate, accessed 12/16/2014. Schutte-Rodin S, et al. Clinical guideline for the evaluation and management of chronic insomnia in adults. J Clin Sleep Med. Oct 15 2008; 4(5): 487-504. (American Academy of Sleep Medicine (AASM) Guideline).

**Decision rationale:** Trazodone is an anti-depressant in the serotonin reuptake inhibitor class of medication. Trazodone is FDA-approved for the treatment of major depression. The primary benefit of this medication on pain management is likely through improved mood. While there is some literature to support the use of trazodone for sleep problems, some research suggests this medication may actually worsen sleep issues. Trazodone is not FDA-approved for this use, and the Guidelines are silent on its use in this setting. The 2008 AASM Guideline and the literature stress the importance of a thorough history in order to establish the type and evolution of insomnia, perpetuating factors, and pertinent concurrent issues. Monitoring data from a sleep diary before and during active treatment is strongly encouraged. Treatment goals should be aimed at improving both the quality and quantity of sleep as well as decreasing daytime impairments. Initial treatment should include at least one behavioral intervention, and all patients should adhere to rules of good sleep hygiene in combination with other therapies. When long-term treatment with medication is needed, consistent follow up, ongoing assessments of benefit, monitoring for adverse effects and evaluation of new or exacerbative issues should occur. The submitted and reviewed records indicated the worker was experiencing pain in the neck and right shoulder, numbness and tingling in the neck and arm, and problems sleeping. The documentation reported the trazodone was recommended to improve sleep. There was no detailed assessment of the worker's sleep problem. There was no discussion suggesting prior behavioral changes had been attempted or encouraged. In the absence of such evidence, the current request for 120 tablets of trazodone 50mg is not medically necessary.

**Biofreeze Gel QTY: 2:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Cryotherapy Units

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48.

**Decision rationale:** The MTUS Guidelines support the use of cold therapy only during the earliest phase of treatment and not for longer than two weeks. The goal is temporary pain relief in order to allow for progressive exercise and activity. The submitted and reviewed records indicated the worker was experiencing pain in the neck and right shoulder and numbness and tingling in the neck and arm for at least several months. Further, the treatment recommendation was to use the cold therapy for months, not days or weeks. For these reasons, the current request for two containers of Biofreeze gel is not medically necessary.

