

<b>Case Number:</b>	CM15-0011144		
<b>Date Assigned:</b>	01/29/2015	<b>Date of Injury:</b>	05/13/2009
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	01/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2015

### 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: California, New York, Florida

Certification(s)/Specialty: Internal Medicine, Pulmonary Disease, Critical Care 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:

The injured worker is a 55-year-old female who reported an injury on 05/13/2009. The mechanism of injury was not provided. Her diagnosis was noted as lumbosacral spondylosis without myelopathy, myofascial pain syndrome, muscle spasm, degenerative disc disease, cervical spondylosis. Past treatments were noted to include medication, home exercise program, and activity modification. The diagnostic studies and surgical history were not provided. During the assessment on 01/14/2015, the injured worker complained of low back pain. The physical examination revealed the injured worker had a tight band and positive jump sign at the right splenius capitis and right supraspinatus muscle. Her medications were noted to include ibuprofen 800 mg, OxyContin 40 mg, hydrocodone/acetaminophen 10/325 mg, trazodone 150 mg, and Imitrex 100 mg. The treatment plan was to request authorization for trigger point injection of the right splenius capitis and right supraspinatus muscle. The rationale for the request was the injured worker used trazodone for depression related to her pain as well as sleep. The Request for Authorization form was not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Trazodone 50mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-16.

**Decision rationale:** The request for trazodone 50mg #60 is not medically necessary. The California MTUS Guidelines recommend antidepressants as a first line medication for treatment of neuropathic pain, and they are recommended especially if pain is accompanied by insomnia, anxiety, or depression. There should be documentation of an objective decrease in pain and objective functional improvement to include an assessment in the changes and the use of other analgesic medications, sleep quality and duration, and psychological assessments. The clinical documentation did not include an assessment in regard to the change in the use of other medications. There was also no indication that a psychological assessment had been performed. Given the above, the request is not medically necessary.