

<b>Case Number:</b>	CM15-0117436		
<b>Date Assigned:</b>	06/25/2015	<b>Date of Injury:</b>	01/04/2002
<b>Decision Date:</b>	07/24/2015	<b>UR Denial Date:</b>	06/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/18/2015

### 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: Arizona, California  
 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 47 year old male who sustained an industrial injury on January 4, 2002. He has reported injury to both wrist, low back, both knee, and both feet and has been diagnosed with carpal tunnel syndrome bilaterally, status post decompression on the right, onset of stenosing tenosynovitis along the long and ring finger bilaterally status post injection, discogenic lumbar condition, S1 radiculopathy, internal derangement of the knee bilaterally, and plantar fasciitis. Treatment has included modified work duty, medical imaging, medications, surgery, injection, and physical therapy. Objective findings note his gait was antalgic and wide based. Facet loading was positive. Extension was no more than 10 degrees. Discomfort along the knee patella with positive compression test. He could not stand on heels and toes. On examination of his hand, he had a positive Tinel's and tenderness along the carpal tunnel area on the left with a positive Phalen's and reverse Phalen's test. He had good thumb palmar abduction and normal two-point discrimination. The treatment request included trazadone, Topamax, and Effexor.

### 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 Antidepressants for Chronic Pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 14-18.

**Decision rationale:** Trazadone is a tricyclic antidepressant. According to the MTUS guidelines, this class of medications is to be used for depression, radiculopathy, back pain, and fibromyalgia. Tricyclic antidepressants have been shown in both a meta-analysis and a systematic review to be effective, and are considered a first-line treatment for neuropathic pain. It has not been proven beneficial for lumbar root pain. In this case, the claimant does have chronic pain and radiculopathy; however, the claimant was on Norco for pain. The Trazadone was not used to replace Norco. The claimant remained on high dose Norco. In addition, it was provided for chronic pain rather than specifically the radiculopathy. There was no mention of depression. The request for Trazadone is not substantiated and not medically necessary.

**Topamax 50mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs (AEDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topamax Page(s): 21.

**Decision rationale:** Topamax has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of "central" etiology. It is still considered for use for neuropathic pain when other anticonvulsants fail. In this case, the claimant did not have neuropathy of central etiology. In addition, the claimant was previously on another anti-epileptic- Neurontin. The Topamax is not indicated for radicular symptoms. The request for Topamax is not justified and is not medically necessary.

**Effexor XR 75mg #60:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OD-mental -SSRI and pg 50.

**Decision rationale:** Effexor is an SNRI. SNRI is indicated for depression and PTSD. In this case, the claimant did not have depression but rather the treating physician felt that the claimant lacked an anti-depressant for chronic pain and provided Trazadone and Effexor. Pain scores were not provided. Need for 2 anti-depressants was not justified. The request for Effexor is not medically necessary.