

Case Number:	CM15-0178780		
Date Assigned:	09/21/2015	Date of Injury:	12/06/2010
Decision Date:	10/22/2015	UR Denial Date:	08/18/2015
Priority:	Standard	Application Received:	09/11/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 65 year old female who sustained an industrial injury on 12-06-2010. The injured worker was diagnosed with left shoulder pain. The injured worker is status post right shoulder arthroscopy in 2002, left shoulder arthroscopy with subacromial decompression synovectomy, complete bursectomy, Mumford and rotator cuff tear tendon repair in February, 2012 and left shoulder arthroscopy revision, rotator cuff repair, extensive scar debridement, manipulation and decompression revision in June 2014. According to the treating physician's progress report on August 11, 2015, the injured worker continues to experience left shoulder pain and is scheduled for surgical intervention on August 27, 2015. Examination of the left shoulder demonstrated restricted range of motion with flexion and abduction at 60 degrees. There was tenderness to palpation in the acromioclavicular joint and biceps groove with positive Hawkins test. Motor strength examination noted shoulder abduction, shoulder external rotation and internal rotation at 4 out of 5 bilaterally. Biceps, brachioradialis and triceps deep tendon reflexes were 2 out of 4 bilaterally. Sensory was within normal limits. Hoffman's sign was negative. Prior treatments documented to date have included diagnostic testing, surgery, left shoulder steroid injections, physical therapy with use of ice machine after therapy, transcutaneous electrical nerve stimulation (TEN's) unit, acupuncture therapy, psychiatric evaluation and treatment, home exercise program and medications. Current medications were listed as Norco 10mg-325mg, Voltaren Gel, Trazodone, Naprosyn and Orphenadrine. Treatment plan consists of the scheduled surgical intervention for August 27, 2015, continuing medication regimen, continuing ice machine, transcutaneous electrical nerve stimulation (TEN's) unit and the current request for Trazodone 50mg #60 with 3 refills. The Utilization Review

determined the request for Trazodone 50mg #60 with 3 refills was not medically necessary on August 18, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazodone 50mg #60 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 (ODG), Pain, Insomnia treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain.

Decision rationale: Trazodone hydrochloride (Desyrel) is an antidepressant chemically unrelated to tricyclic, tetracyclic, or other known antidepressant agents and is indicated for the treatment of major depression. MTUS Medical Treatment Guidelines specifically do not recommend for Trazodone. Tolerance may develop and rebound insomnia has been found even after discontinuation, but may be an option in patients with coexisting depression that is not the case here. There are no evidence-based studies showing indication or efficacy for treatment of trazodone in insomnia. Submitted reports have not demonstrated functional benefit derived from the previous treatment rendered for this chronic 2010 injury. The Trazodone 50mg #60 with 3 refills is not medically necessary and appropriate.