

<b>Case Number:</b>	CM15-0092957		
<b>Date Assigned:</b>	05/19/2015	<b>Date of Injury:</b>	07/13/2009
<b>Decision Date:</b>	06/25/2015	<b>UR Denial Date:</b>	04/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/14/2015

### 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: New Jersey, Alabama, California

Certification(s)/Specialty: Neurology, Neuromuscular 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 56 year old female, who sustained an industrial/work injury on 7/13/09. She reported initial complaints of neck, back, and arm pain. The injured worker was diagnosed as having cervical radiculitis, chronic pain disorder, lumbar radiculopathy, right carpal tunnel syndrome, bilateral elbow pain, osteoarthritis of the left shoulder, and left sided shoulder bursitis. Treatment to date has included medication, acupuncture, and referral for specialty evaluation. MRI results were reported on 11/17/14 of the left scapula that indicated no specific abnormality of the left scapular region, probable mild arthrosis of the glenohumeral joint on limited imaging. MRI of the left shoulder on 10/16/14 revealed mild degenerative hypertrophic changes of the acromioclavicular joint without encroachment upon the underlying supraspinatus muscles or tendon. MRI of the left upper extremity on 3/18/14 revealed low grade partial thickness intra-substance delamination tear of the infraspinatus tendon at the footprint on a background of tendinosis and mild acromioclavicular joint osteoarthritis. MRI of the cervical spine on 3/4/14 noted mild straightening of cervical lordosis, effacement of anterior thecal sac at C3-4, C4-5, C5-6, and C6-7, at C4-5 a 2 mm left paracentral disc protrusion. Electromyography and nerve conduction velocity test (EMG/NCV) was performed on 9/19/14 revealed active chronic right L5 radiculopathy. Currently, the injured worker complains of exacerbation of neck pain that radiates down bilateral upper extremities in left shoulder, right hand, elbows, and back pain that radiated down bilateral lower extremities. Pain was 4/10 with medications and 8/10 without. Per the primary physician's progress report (PR-2) on 4/7/15, the injured worker is following up for pain

medicine and re-examination. Exam reported observation to be in moderate distress, tenderness upon palpation at the bilateral parvertebral C4-7 area, myofascial trigger points with twitch response in the left rhomboids muscles, and range of motion was limited in the cervical spine. The lumbar exam noted tenderness in bilateral paravertebral L4-S1 levels, myofascial trigger points with twitch response noted in the left rhomboids, limited range of motion, and positive straight leg raise on the right at 50 degrees. The right wrist has a splint with tenderness on palpation to the left posterior shoulder, bilateral elbows, right wrist, right hand. The left shoulder has decreased range of motion with popping sounds. There is tenderness on palpation at the right ankle and mild swelling. The requested treatments include Prozac 20 mg, Trazodone 150 mg, and Vistaril 25 mg.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Prozac 20 mg Qty 180 (frequency, duration & refill unspecified): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Goodman & Gilman's The Pharmacological Basis of Therapeutics, 2010; Physician's Desk Reference, 68th edition; Official Disability Guidelines: Workers' Compensation Drug Formulary.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.rxlist.com/prozac-drug.htm>.

**Decision rationale:** Prozac is a selective serotonin reuptake inhibitor indicated in case of depression. There is no clear objective documentation of functional gains supporting the patient's claim that her depression symptoms are helped significantly with Prozac. Therefore, the request for prescribing Prozac 20mg #180 is not medically necessary.

**Trazodone 150 mg Qty 90 (frequency, duration & refill unspecified): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Goodman & Gilman's The Pharmacological Basis of Therapeutics, 2010; Physician's Desk Reference, 68th edition; Official Disability Guidelines: Workers' Compensation Drug Formulary.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Schwartz, T., et al. (2004). "A comparison of the effectiveness of two hypnotic agents for the treatment of insomnia." *Int J Psychiatr Nurs Res* 10 (1): 1146-1150.

**Decision rationale:** According to the Official Disability Guidelines, Pain chapter, insomnia treatment, medications are an option after careful evaluation of the insomnia condition, and behavioral treatments are the best long-term treatment. "Sedating antidepressants (e.g., amitriptyline, trazodone, mirtazapine) have also been used to treat insomnia; however, there is less evidence to support their use for insomnia (Buscemi, 2007) (Morin, 2007), but they may be an option in patients with coexisting depression. (Morin, 2007) Trazodone is one of the most

commonly prescribed agents for insomnia. Side effects of this drug include nausea, dry mouth, constipation, drowsiness, and headache. Improvements in sleep onset may be offset by negative next-day effects such as ease of awakening. Tolerance may develop and rebound insomnia has been found after discontinuation." There is no recent documentation that the patient is suffering from insomnia. There is no documentation that secondary causes of insomnia were excluded. There is no documentation that the patient tried first line non-pharmacological treatment of her insomnia. Therefore, Trazadone 150mg #90 is not medically necessary.

**Vistaril 25 mg Qty 90 (frequency, duration & refill unspecified): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Goodman & Gilman's The Pharmacological Basis of Therapeutics, 2010; Physician's Desk Reference, 68th edition; Official Disability Guidelines: Workers' Compensation Drug Formulary.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-Benzodiazepine sedative-hypnotics (Benzodiazepine-receptor agonists (<http://worklossdatainstitute.verioiponly.com/odgtwc/pain.htm>).

**Decision rationale:** Vistaril is a sedative antihistaminic drug proposed by the provider to treat the patient insomnia and anxiety. However, tolerance to this drug may develop within few days. According to ODG guidelines, pharmacological treatment of insomnia is not recommended without full characterization of the sleep disorder (primary sleep problem or secondary to the patient pain, medical or psychiatry disorders). Therefore, the request for Vistaril 25mg #90 is not medically necessary.