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| Case Number: | CM13-0065871 | | |
| Date Assigned: | 01/03/2014 | Date of Injury: | 07/25/2006 |
| Decision Date: | 05/19/2014 | UR Denial Date: | 12/10/2013 |
| Priority: | Standard | Application Received: | 12/14/2013 |

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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:

This case involves a 49 year-old male who was injured on 7/25/2006. He has been diagnosed with lumbar disc displacement without myelopathy; lumbar disc degeneration; sciatica; long term use of medications. According to the 11/18/13 pain management report, the patient presents with 5-6/10 back and bilateral lower extremity pain. With activity pain increases to 8-9/10. Medications help him cope with pain and function. He takes morphine 15mg tid; and Norco 6/day. He is reluctant to increase morphine due to dry mouth and drowsiness side effects. He uses gabapentin but is not sure if it helps. He uses trazodone for sleep. On 12/10/13 UR modified the request for trazodone to allow 10 tablets for weaning.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRAZODONE 50MG, #90, ONE (1) TABLET AT BEDTIME,: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG MENTAL ILLNESS & STRESS, TRAZODONE (DESYREL).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTIDEPRESSANTS FOR CHRONIC PAIN Page(s): 13-16. Decision based on Non-MTUS

Citation OFFICIAL DISABILITY GUIDELINES (ODG), STRESS/MENTAL CHAPTER, FOR TRAZODONE

Decision rationale: According to the 11/18/13 pain management report the patient presents with 5-6/10 back and bilateral lower extremity pain. I have been asked to review for Trazodone for sleep. The ODG guidelines state trazodone is "Recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety" I have reviewed 6-months of medical record back from 11/18/13, including the 10/21/13, 9/23/13, 8/26/13, 8/20/13, 7/29/13, 7/19/13, 7/1/13, 6/6/13 and 5/7/13, looking specifically for documentation of any coexisting psychiatric symptoms such as depression or anxiety. There was no indication of coexisting psychiatric conditions. The use of Trazodone for insomnia without potentially coexisting psychiatric symptoms is not in accordance with the ODG guidelines.