

Case Number:	CM14-0013211		
Date Assigned:	02/24/2014	Date of Injury:	05/18/2007
Decision Date:	06/26/2014	UR Denial Date:	01/17/2014
Priority:	Standard	Application Received:	02/03/2014

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 Anesthesiologist and is licensed to practice in Texas. 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:

The injured worker is a 56 year old male injured on 05/18/07 when he fell resulting in right hip/proximal hip femur fracture. Current diagnoses include lumbar post-laminectomy syndrome status post L2-3, L3-4, and L4-5 posterior lumbar interbody fusion on 02/10/10, lumbar spinal cord stimulator implant on 01/20/11, bilateral lower extremity radiculopathy, right hip ORIF in 2008, cervical spine sprain/strain syndrome, cervicogenic headaches, reactionary depression/anxiety, and medication induced gastritis. The clinical documentation indicates the injured worker continues to complain of neck pain with associated cervicogenic headaches as well as pain radiating down his right upper extremity. Additionally, the injured worker has ongoing pain in his right hip and groin. The injured worker underwent a right hip injection in May of 2013 with excellent pain relief. The documentation indicates the injured worker experiences increased pain in his low back with radiation down the right lower extremity rated at 8/10 with 60% relief of radicular symptoms in his lower extremity from spinal cord stimulator. Medications include Percocet 10/325mg 3-4 Q day, Anaprox DS 550mg BID, Prilosec 20mg 2-3 tablets BID, Neurontin 600mg QID, Xanax 0.5mg BID, Doral 15mg QHS, Wellbutrin 100mg BID, FexMid 7.5mg BID, Trazadone 100mg 1-2 QHS, and Dendracin topical analgesic QID PRN. The documentation indicates the injured worker receives individual cognitive behavioral psychotherapy sessions which have been beneficial in stabilizing his mood. The initial request for Trazadone 100mg 1-2 QHS #60 was initially not medically necessary on 01/17/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRAZODONE 100MG 1-2 QHS #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Antidepressants For Chr.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress , Trazodone (Desyrel)

Decision rationale: As noted in the Official Disability Guidelines, Trazadone is recommended as an option for insomnia only for injured workers with potentially coexisting mild psychiatric symptoms such as depression or anxiety. This injured worker has been diagnosed with depression and is being treated with cognitive behavioral therapy; however, there is no documentation in recent clinical notes that the injured worker suffers from insomnia. As such, the request for Trazadone 100mg 1-2 QHS #60 cannot be recommended as medically necessary.