

Case Number:	CM14-0019010		
Date Assigned:	04/23/2014	Date of Injury:	05/22/2007
Decision Date:	07/03/2014	UR Denial Date:	02/06/2014
Priority:	Standard	Application Received:	02/14/2014

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 Emergency Medicine 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:

Patient has a reported date of injury of 5/22/2007. No mechanism of injury was provided. Patient has a diagnosis of low back pain, bilateral iliolumbar/sacroiliac enthesopathy, bilateral tranchantheric bursitis, L S1 radiculopathy, R bicepital tendonitis and R subacromial bursitis. Patient is post decompression laminectomy at L4-5 and L5-S1, medial facetectomy of L4-5 and L5-S1, foraminotomies at L4-5, ant/post fusion at L4-S1 and pro disc disc replacement at L3-4. Pt had reportedly underwent implantation of neurostimulator with reported several revisions. Last revision was on 8/15/13. Multiple medical reports from primary treating physician and consultants reviewed. Last report available until 4/2/14. Patient complains of low back pain. 0/10(potential typo vs resolution of pain with spinal stimulator) bilateral radiating pain. Pain reportedly improving after placement of neurostimulator. Patient also complaining of burning sensation over R abdominal pulse generator. Objective exam reveals absent L achilles tendon reflex and trace R sided reflex. Decreased sensation in toes. Motor strength is 3+/5 in bilateral hips flexion, 4/5 throughout all other muscle groups in hips and legs. There is mild decreased range of motion (ROM) of both hips. Patient has reportedly completed physical therapy with improvement. Medication includes Gabapentin, Topirimate and Savella. Patient is apparently off opioids. Utilization review is for prescription for Trazodone 50mg #120. Prior UR on 2/6/14 recommended non-certification. That UR approved prescriptions for Gabapentin, Topiramate and Savella.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRAZODONE 50MG, #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTIDEPRESSANTS FOR CHRONIC PAIN Page(s): 13-15.

Decision rationale: Trazodone is a type of anti-depressant medication that is also often used for sleep. As per Chronic Pain Medical Treatment Guidelines, anti-depressants may be considered for neuropathic pain. However, evidence does not support its use in low back pain except for tricyclic antidepressants. There is also little evidence to support its use for radicular pain. Since patient's pain has improved significantly after placement of the neurostimular and evidence does not support its use in low back/radicular pain, the request for Trazodone is not medically necessary.