

Case Number:	CM14-0167387		
Date Assigned:	10/14/2014	Date of Injury:	08/15/1998
Decision Date:	12/22/2014	UR Denial Date:	09/06/2014
Priority:	Standard	Application Received:	10/10/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain 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:

This is a patient with a date of injury of 8/15/98. A utilization review determination dated 9/6/14 recommends non-certification of baclofen. Trazodone was certified. 8/27/14 medical report identifies that without current medications, the patient will not be able to get out of bed and perform ADLs. Flecainide has been denied and she is at risk for seizure. Patient reports increased cramping and spasms in the right arm and hand since discontinuing Flecainide, causing the patient difficulty to sleep. On exam, there is tenderness, limited range of motion (ROM), give-away weakness right thumb/wrist and bilateral hips and knee, coolness and sweating of the right hand and BLEs left greater than right, decreased left L2 sensation, allodynia over the right hand, distal forearm, parascapular region, and bilateral thighs and calves. Recommendations include multiple medications. Trazodone was prescribed for 100 mg tablets 2 PO QHS.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazodone HCL 100mg #60 x 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain Page(s): 13-16.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Insomnia treatment

Decision rationale: Regarding the request for trazodone, it appears that the medication is being utilized to treat insomnia. California MTUS guidelines are silent regarding the issue. Official Disability Guidelines (ODG) recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days may indicate a psychiatric or medical illness. Within the documentation available for review, there is no description of the patient's insomnia complaints, no statement indicating what behavioral treatments have been attempted for the condition, and no statement indicating how the patient has responded to prior treatment with trazodone. Finally, there is no indication that the medication is being used for short-term treatment, as recommended by guidelines. In the absence of such documentation, the currently requested trazodone is not medically necessary.