

Case Number:	CM14-0066510		
Date Assigned:	07/11/2014	Date of Injury:	03/09/2011
Decision Date:	10/07/2014	UR Denial Date:	05/05/2014
Priority:	Standard	Application Received:	05/09/2014

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 and is licensed to practice in Nevada. 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 records presented for review indicate that this 53 year-old individual was reportedly injured on 3/9/2011. The mechanism of injury is noted as a twisting injury. The most recent progress note, dated 5/27/2014, indicates that there are ongoing complaints of low back pain and bilateral leg pain. The physical examination demonstrated: patient walks with an antalgic forward flexion gait utilizing a seated walker for ambulation. Positive tenderness to palpation of the SI joints bilaterally and right lumbar paravertebral musculature. Sensory is decreased over the right L3-L4 dermatome distributions. Decreased range of motion with pain. Bilateral lower extremities reflexes are absent. Muscle strength 5/5. Positive by rest, positive compression test, positive Fortin's sign, positive facet loading. No recent diagnostic studies are available for review. Previous treatment includes medications, and conservative treatment. A request had been made for trazodone 100 mg #120 and was not certified in the pre-authorization process on 5/5/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazadone 100mg QTY: 120.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Mental Illness & Stress

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) - Chronic Pain - Clinical Measures - Medications: Antidepressants (electronically sited).

Decision rationale: Trazodone (Desyrel) is an antidepressant of the serotonin antagonists and reuptake inhibitor (SARI) with anti-anxiety and sleep-inducing effects. MTUS/ACOEM practice guidelines do not support trazodone for treatment of chronic persistent pain without depression. Review of the available medical records, fails to document a diagnosis of depression. As such, this request is not considered medically necessary.