

Case Number:	CM13-0037082		
Date Assigned:	12/13/2013	Date of Injury:	12/13/1989
Decision Date:	01/27/2015	UR Denial Date:	10/07/2013
Priority:	Standard	Application Received:	10/23/2013

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 Rehab, 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 December 13, 1989. A utilization review determination dated October 7, 2013 recommends modified certification of trazodone and Zoloft. Partial certification of trazodone is recommended to allow a 30 a trial and partial certification of Zoloft was recommended due to lack of documentation that the patient has failed treatment with first-line agents for chronic pain. A progress report dated December 12, 2014 identifies subjective complaints of low back pain that radiates down the legs. The note states that "meds are helpful no side effects." The note identifies pain radiating into the right leg 's 1 distribution. Pain is rated as 8/10 with medications. Current medications include OxyContin, Zoloft (started September 18, 2014) and trazodone (started on September 18, 2014). Trazodone is dosed QHS. Review of systems indicates that the patient denied insomnia and fatigue and complained of anxiety and depression. Diagnoses include lumbago, radiculitis, and pain in the foot/leg/arm/finger. The treatment plan recommends continuing OxyContin. A progress note dated November 17, 2014 indicates that the patient still suffers from depression and takes Zoloft 100 mg every day and has problems sleeping and takes Seroquel at bedtime. The progress report dated September 18, 2014 states that the patient has depression and anxiety and cries a lot. The note goes on to state that the antidepressants "do help."

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazodone 50mg Qty 30 With 5 Refills: Upheld

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

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

Decision rationale: Regarding the request for Trazodone, California MTUS guidelines are silent regarding the use of sedative hypnotic agents. 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. It is recommended that treatments for insomnia should reduce time to sleep onset, improve sleep maintenance, avoid residual effects and increase next-day functioning. Within the documentation available for review, there are no subjective complaints of insomnia, no discussion regarding how frequently the insomnia complaints occur or how long they have been occurring, no statement indicating what behavioral treatments have been attempted for the condition of insomnia, and no statement indicating how the patient has responded to Trazodone treatment. In the absence of such documentation, the currently requested Trazodone is not medically necessary.

Zoloft 100mg Qty 30 With 5 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 395-396, 402, Chronic Pain Treatment Guidelines Page(s): 107.

Decision rationale: Regarding the request for Zoloft (sertraline), Chronic Pain Medical Treatment Guidelines state that selective serotonin reuptake inhibitors may have a role in treating secondary depression. Additionally, guidelines recommend follow-up evaluation with mental status examinations to identify whether depression is still present. Guidelines indicate that a lack of response to antidepressant medications may indicate other underlying issues. Within the documentation available for review, there is no evidence of any recent mental status examinations to determine a diagnosis of depression. Additionally, there is no documentation indicating whether or not the patient has responded to the current Zoloft treatment, other than a non-specific statement indicating that it "helps". A one-month prescription of Zoloft may be reasonable to allow the treating physician time to better document the medical necessity and efficacy of Zoloft. But, unfortunately, there is no provision to modify the current request. As such, the currently requested Zoloft is not medically necessary.