

Case Number:	CM15-0132114		
Date Assigned:	07/20/2015	Date of Injury:	01/14/2013
Decision Date:	08/24/2015	UR Denial Date:	07/02/2015
Priority:	Standard	Application Received:	07/09/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, Arizona, Maryland
 Certification(s)/Specialty: Psychiatry

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 48 year old male who sustained an industrial injury on 01/14/2013 when he fell off a six foot ladder and hit the back of his head with loss of consciousness. The injured worker was diagnosed with post-concussion syndrome, cervicocranial syndrome, cervicogenic headaches, reactive depression, cognitive difficulties and insomnia. Treatment to date has included diagnostic testing with cervical spine magnetic resonance imaging (MRI) in February 2014, brain magnetic resonance imaging (MRI) in December 2014 reported as negative findings and magnetic resonance arthrogram (MRA) brain in November 2014 (grossly normal), acupuncture therapy, vestibular physical therapy evaluation and treatment, neuropsychiatric visits, physical therapy (10 sessions completed), transcutaneous electrical nerve stimulation (TEN's) unit, ENT consultation, four point cane and medications. According to the primary treating physician's progress report on June 3, 2015, the injured worker continues to experience headaches with vertigo, imbalance, nausea and photophobia, jaw pain, facial numbness and fullness in his ears. Examination of the cervical spine demonstrated tenderness over the posterior cervical paraspinal muscles of C3 through C7 with flexion well tolerated but painful and extension being limited. There was tenderness to palpation over the bilateral temporomandibular areas, worse on the left side. There was no evidence of pathological nystagmus on extra ocular movements (EOM). Minimal tenderness was noted over the bilateral trapezii with full strength in the upper extremities. The injured worker ambulated with a quad cane for stability. Current medications are listed as Norco 5/325mg, Topiramate, Trazodone, Valium 5mg, Meclizine and Prozac. Treatment plan consists of continue neuropsychiatric follow-ups, continue with

medication regimen and trial Topamax, transcutaneous electrical nerve stimulation (TEN's) unit, cervical epidural steroid injection, vestibular physical therapy sessions and the current request for Trazodone.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazodone tab 50mg #90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness & Stress (Online Version); ODG, Pain Chapter (Online Version).

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

Decision rationale: ODG states "Trazodone: Recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. See also Insomnia treatment, where it says there is limited evidence to support its use for insomnia, but it may be an option in patients with coexisting depression. See also Fibromyalgia in the Pain Chapter, where trazodone was used successfully in fibromyalgia. Trazodone was approved in 1982 for the treatment of depression. It is unrelated to tricyclic or tetracyclic antidepressants and has some action as an anxiolytic. Off-label uses include alcoholism, anxiety, insomnia, and panic disorder. Although approved to treat depression, the American Psychiatric Association notes that it is not typically used for major depressive disorder. Over the period 1987 through 1996, prescribing trazodone for depression decreased throughout the decade, while off-label use of the drug for insomnia increased steadily until it was the most frequently prescribed insomnia agent. To date, there has been only one randomized, double blind, placebo-controlled trial studying trazodone in primary insomnia. It was observed that relative to placebo, patients reported significant improvement in subjective sleep latency, sleep duration, wake time after sleep onset, and sleep quality with trazodone and zolpidem during week one, but during week two the trazodone group did not differ significantly from the placebo group whereas the zolpidem group demonstrated significant improvement compared to placebo for sleep latency and sleep duration. (Walsh, 1998) The AHRQ Comparative Effectiveness Research on insomnia concludes that trazodone is equal to zolpidem. (AHRQ, 2008) Evidence for the off-label use of trazodone for treatment of insomnia is weak. The current recommendation is to utilize a combined pharmacologic and psychological and behavior treatment when primary insomnia is diagnosed. Also worth noting, there has been no dose-finding study performed to assess the dose of trazodone for insomnia in non-depressed patients. Other pharmacologic therapies should be recommended for primary insomnia before considering trazodone, especially if the insomnia is not accompanied by comorbid depression or recurrent treatment failure. There is no clear-cut evidence to recommend trazodone first line to treat primary insomnia. (Mendelson, 2005)" The injured worker has been prescribed Trazodone 50 mg one or two tablets at bedtime for sleep. The request for Trazodone tab 50 mg # 90 is not medically necessary as he has been prescribed this

medication for over a year now with no evidence of objective functional improvement. It is not indicated for insomnia medications to be continued on a long-term basis.