

Case Number:	CM15-0040438		
Date Assigned:	03/10/2015	Date of Injury:	10/13/2001
Decision Date:	04/14/2015	UR Denial Date:	02/02/2015
Priority:	Standard	Application Received:	03/03/2015

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: North Carolina, Georgia
 Certification(s)/Specialty: Family Practice

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 51 year old female, who sustained an industrial injury on October 13, 2001. The injured worker had reported low back pain. The diagnoses have included chronic pain syndrome, lumbago, thoracic or lumbar radiculitis or neuritis, sacroilitis and a lumbar four-sacral one fusion. Treatment to date has included medications, radiological studies, bilateral lumbar medial nerve blocks and lumbar surgery. Current documentation dated November 20, 2014 notes that the injured worker complained of constant low back pain. Physical examination of the lumbar spine revealed tenderness to palpation of the lumbosacral spine and bilateral facet joints at lumbar two-lumbar four. The injured worker was also noted to have lumbar paraspinal muscle spasms and a painful range of motion. A Fabere test was noted to be positive bilaterally. The treating physician's recommended plan of care included a refill of the medication Trazadone for sleep. Current requested treatments include Trazadone 50 mg # 30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazodone 50 mg #30: 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), pain chapter.

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

Decision rationale: The CA MTUS is silent on the use of Ambien. ODG addresses insomnia treatments in the section on pain. ODG states that treatment should be based on the etiology of the insomnia. Pharmacologic agents should be used only after a careful investigation for cause of sleep disturbance. Primary insomnia should be treated with pharmacologic agents while secondary insomnia may be treated with pharmacologic and/or psychological measures. It is important to address all four components of sleep onset, sleep maintenance, sleep quality and next day function. There is no documentation of any investigation of causes of insomnia or of any conservative treatment. Trazadone 50 mg #30 is not medically indicated.