

<b>Case Number:</b>	CM15-0048335		
<b>Date Assigned:</b>	03/20/2015	<b>Date of Injury:</b>	09/06/2009
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/13/2015

### 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  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 35-year-old male who sustained an industrial injury on 09/06/2009. Current diagnoses include traumatic brain injury, pelvis fracture, and left femur fracture. Previous treatments included medication management. Report dated 02/10/2015 noted that the injured worker presented with complaints that included left leg pain. Pain level was rated as 8 out of 10 on the visual analog scale (VAS) without medications. The injured worker noted that with medications pain level decreases to 3 out of 10 on VAS and is able to do activities of daily living and function. Physical examination was not provided. Of note, much of the report was not legible due to handwriting. The treatment plan included medication refill and need for an interpreter. Requested treatment included Trazadone.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Trazadone 100 mg, thirty count with three refills:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13-15. Decision based on Non-MTUS Citation Official disability guidelines stress/mental chapter: Trazodone.

**Decision rationale:** According to the 12/09/2014 hand written report, this patient presents with "daily, pelvic and back pain, 8/20 with meds" and "still problem with sleep." The current request is for Trazadone 100 mg, thirty count with three refills. The request for authorization is on 02/10/2015. The patient's work status was not mentioned in the provided reports. Trazodone is classified as an anti-depressant. The MTUS Guidelines on antidepressants page 13 to 16 states, "recommended as a first line option for neuropathic pain and is a possibility for non-neuropathic pain." ODG Guidelines stress/mental chapter, for Trazodone, has the following to say, "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." In reviewing the provided reports indicates that the patient is prescribed Trazadone for apparent insomnia and depression. The treating physician states "Trazadone 100mg helps with sleep and mood." In this case, the patient has insomnia and depression and the treating physician documented the efficacy of the medication as required by the MTUS guidelines. The current request IS medically necessary.