

Case Number:	CM15-0049740		
Date Assigned:	04/14/2015	Date of Injury:	12/22/2010
Decision Date:	05/11/2015	UR Denial Date:	02/19/2015
Priority:	Standard	Application Received:	03/16/2015

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: New York, Tennessee
 Certification(s)/Specialty: Emergency Medicine

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 December 22, 2010. He reported low back pain, left lower extremity pain, bilateral shoulder and neck pain. The injured worker was diagnosed as having chronic low back pain and left lower extremity pain, left shoulder pain status post bilateral shoulder surgeries. Treatment to date has included radiographic imaging, diagnostic studies, surgical interventions of the shoulders, conservative care, medications and work restrictions. Currently, the injured worker complains of left shoulder, neck and back pain. The injured worker reported an industrial injury in 2010, resulting in the above noted pain. He was treated conservatively and surgically without complete resolution of the pain. Evaluation on April 3, 2015, revealed continued pain as noted. Trazadone was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazadone 100mg Qty: 60.00 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-14.

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

Decision rationale: Trazodone is a tetracyclic antidepressant usually prescribed for insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. Insomnia treatment should be based on etiology. Most medications have only been evaluated for short-term use (less than 4 weeks). Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Sedating antidepressants are often used to treat insomnia; however, there is less evidence to support their use for insomnia. They may be an option in patients with coexisting depression. Trazodone is one of the most commonly prescribed agents for insomnia. Side effects of this drug include nausea, dry mouth, constipation, drowsiness, and headache. Negative next-day effects such as ease of awakening may offset improvements in sleep onset. Tolerance may develop and rebound insomnia has been found after discontinuation. The patient has been taking this medication since at least August 2012. There is no increased documentation that the patient has insomnia or psychiatric disease that would require treatment with trazodone. Increased duration of treatment increases the risk of tolerance and other adverse effects. The request should not be authorized. Therefore, the requested medical treatment is not medically necessary.