

Case Number:	CM15-0018060		
Date Assigned:	02/05/2015	Date of Injury:	05/26/2003
Decision Date:	03/25/2015	UR Denial Date:	01/15/2015
Priority:	Standard	Application Received:	01/30/2015

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, Indiana, New York
 Certification(s)/Specialty: Internal 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 (IW) is a 67 year old female who sustained an industrial injury on 05/26/2003 when she fell approximately 10 feet from a ladder. She has reported pain in the low back, right ankle, neck and ribs. Currently, she has somatic complaints of cervical, thoracic and lumbar spine pain with the pain in the low back radiating down both lower extremities . She also complains of left lower ribcage pain, coccygeal pain, and neck pain. Other complaints were of headaches, depression, anxiety and intermittent stomach upset she feels is due to medications. Diagnoses includes lumbar strain, L3 compression fracture, right greater than left lumbar radiculopathy, status post left lower rib fracture, significant lower ribcage pain, coccygeal fracture with coccygodynia, right ankle strain, cervical strain, post-traumatic headaches, mid thoracic strain, and secondary depression due to chronic pain. Treatment to date includes physical therapy, anti-inflammatory medication, and diagnostic radiologic studies. In a progress note dated 12/09/2014, the treating provider notes the IW was considered permanent and stationary for the physical complaints on 01/20/2006 and has open future care. In the interim history, psychiatric evaluation was approved but an appointment has not yet been scheduled. In his notes he reports that the IW currently complains of low back pain with radiation to bilateral lower extremities, worse on the left than the right, Left lower ribcage pain, coccygeal pain, neck pain , headaches, depression and anxiety due to continued pain, and intermittent stomach upset due to medication use. The IW's pain increases with cold weather and decreases with pain medication. Objectively the IW had a slow gate, exhibited symptoms of mild depression, and moderate tenderness and spasm in the paralumbar muscles bilaterally. Lumbar spine range of

motion is diminished in all planes; straight leg raise was positive bilaterally causing low back, posterior thigh, and calf pain. Slight spasm was present in the interscapular parathoracic muscles at T6-T12, and right thoracic rotation was decreased. On 01/15/2015 Utilization Review modified a request for one prescription of Trazodone 100mg, #30 to one prescription of Trazodone 100 mg #23 noting there was no record of significant improvement with this medication and weaning should be started. The Official Disability Guidelines, Mental Illness & Stress, Insomnia treatment were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prescription of Trazodone 100mg, #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, Mental Illness & Stress, Insomnia treatment

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13, 16, 107. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain section, Antidepressants

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Trazodone 100 mg #30 is not medically necessary. Trazodone is recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. See the guidelines for additional details. In this case, the injured worker's working diagnoses are secondary depression due to chronic pain; lumbar strain with L3 compression fracture and right greater than left radiculopathy; status post left lower rib fracture confirmed with bone scan current significant left lower rib cage pain, improving; coccygeal fracture; right ankle strain, resolved; cervical strain, mostly right-sided; posterior malic headache; and mid thoracic strain. The injured worker has a documented history of depression. Trazodone is an antidepressant and is indicated for depression based on the medical documentation. The documentation does not contain evidence of objective functional improvement as it pertains to ongoing long-term trazodone use. Consequently, due to absent clinical documentation with objective functional improvement of Trazodone, Trazodone 100 mg #30 is not necessary.