

<b>Case Number:</b>	CM15-0175438		
<b>Date Assigned:</b>	09/16/2015	<b>Date of Injury:</b>	12/04/2009
<b>Decision Date:</b>	10/26/2015	<b>UR Denial Date:</b>	08/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/04/2015

### 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, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative 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 33 year old female with an industrial injury dated 12-04-2009. A review of the medical records indicates that the injured worker is undergoing treatment for thoracic and lumbar sprain and strain, lumbar spine herniated nucleus pulposus with S1 radiculopathy and foot drop, major depression, generalized anxiety disorders and psychological condition affecting medical factors. Treatment consisted of diagnostic studies, prescribed medications, physical therapy, home exercise program and periodic follow up visits. In a progress report dated 04-17-2015, the injured worker reported left leg complaints, mid and low back pain, loss of sleep and sharp left buttock pain. Objective findings revealed tenderness with muscle spasms in the lumbar spine and positive bilateral straight leg raising. No mental status exam was included in 04-17-2015 medical report. In a qualified medical evaluation dated 07-27-2015, the injured worker reported chronic, ongoing moderate to severe depression and anxiety, social isolation and feelings of helplessness. Objective findings revealed Beck scales: Beck Depression Inventory III equals 46 for severe depression. The treating physician prescribed services for Trazodone tab 50mg #30 with 1 refill, now under review. Utilization Review (UR) determination on 08-05-2015 partially approved the request for Trazodone tab 50mg #30 (original with 1 refill).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Trazodone tab 50mg #30 with 1 refill: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain chapter - Trazodone.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Sleep Medication, Insomnia treatment.

**Decision rationale:** Regarding the request for Trazodone tab 50mg #30 with 1 refill, guidelines state that antidepressants are recommended as a 1st line option for neuropathic pain and as a possibility for non-neuropathic pain. Guidelines go on to recommend a trial of at least 4 weeks. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. It is recommended that treatments for insomnia should reduce time to sleep onset, improve sleep maintenance, avoid residual effects and increase next-day functioning. Within the documentation available for review, there is no identification that the Trazodone provides any specific analgesic effect (in terms of reduced numeric rating scale or percent reduction in pain), or provides any objective functional improvement, or improvement in psychological well-being. In Addition, there is no discussion regarding how frequently the insomnia complaints occur or how long they have been occurring, no statement indicating what behavioral treatments have been attempted for the condition of insomnia, and no statement indicating how the patient has responded to trazodone treatment. In the absence of clarity regarding those issues, the currently requested Trazodone tab 50mg #30 with 1 refill is not medically necessary.