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| Case Number: | CM15-0042236 | | |
| Date Assigned: | 03/12/2015 | Date of Injury: | 03/01/2008 |
| Decision Date: | 04/22/2015 | UR Denial Date: | 02/24/2015 |
| Priority: | Standard | Application Received: | 03/05/2015 |

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 Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 64 year old female, who sustained an industrial injury on March 1, 2008. The injured worker reported low back pain. The injured worker was diagnosed as having lumbar facet syndrome, lumbar degenerative disc disease (DDD) and low back pain. Treatment and diagnostic studies to date have included X-rays, magnetic resonance imaging (MRI), lumbar blocks and oral medications. A progress note dated February 5, 2015 the injured worker complains of low back pain rated 3.5/10 with medication. Physical exam notes a normal gait, restricted lumbar range of motion (ROM) and tenderness on palpation. The plan includes home exercise program, topical patches, oral medication and lab blood work.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazodone 50mg #60 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Trazodone.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Schwartz, T., et al. (2004). "A comparison of the

effectiveness of two hypnotic agents for the treatment of insomnia"." Int J Psychiatr Nurs Res 10(1): 1146-1150.

Decision rationale: There is no clear evidence that the patient was diagnosed with major depression requiring Trazodone. There is no formal psychiatric evaluation documenting the diagnosis of depression requiring treatment with Trazodone. In addition, there is no documentation of failure of first line treatments for insomnia and depression. Therefore, the request for Trazodone 50 MG #60 with 2 Refills is not medically necessary.