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| Case Number: | CM15-0096180 | | |
| Date Assigned: | 05/26/2015 | Date of Injury: | 10/26/2010 |
| Decision Date: | 06/26/2015 | UR Denial Date: | 04/20/2015 |
| Priority: | Standard | Application Received: | 05/19/2015 |

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: Preventive Medicine, Occupational 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 46 year old female, who sustained an industrial injury on 10/26/2010. The details regarding the initial injury were not submitted for this review. Diagnoses include lateral epicondylitis, bursitis, psychogenic pain, major depression, insomnia and anxiety. Treatments to date include medication therapy, acupuncture treatments, cortisone injections, psychotherapy, and hypnotherapy. Currently, she reported recent changes in work and personal environments leading to increased sleep and decrease3d stress occurring in the previous week. On 4/20/15, the group psychotherapy progress note documented review of relaxation skills, values and exposure. This was noted as the sixth session attended. The treating diagnoses included major depressive disorder, single episode, in remission, and insomnia due to mental disorder. The provider documented that benefit was gained from group therapy and the injured worker shoulder continue to attend. The plan of care included Effexor XR 75mg tablets, one tablet twice daily #60 with one refill and psychoeducational group for anxiety/cognitive behavioral therapy once a week for six weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazodone 100 mg Qty 60 with 1 refill: 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 - Antidepressants for treatment of MDD (major depressive disorder).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), Antidepressants for chronic pain.

Decision rationale: Trazodone is a tetracyclic antidepressant used to treat depression and anxiety disorders. The Official Disability Guidelines recommend numerous antidepressants in a number of classes for treating depression and chronic pain. Trazodone is not contained within the current recommendations by the ODG. Trazodone 100 mg Qty 60 with 1 refill is not medically necessary.

Follow up office visit, Medication Management, 1 time per month for 6 months, 6 visits:
Upheld

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 9792.20 - 9792.26 Page(s): 8.

Decision rationale: The physician should periodically review the course of treatment of the patient and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of pain management depends on the physician's evaluation of progress toward treatment objectives. If the patient's progress is unsatisfactory, the physician should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities. When prescribing controlled substances for pain, satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Follow up office visit, Medication Management, 1 time per month for 6 months, 6 visits is not medically necessary.