

<b>Case Number:</b>	CM14-0185535		
<b>Date Assigned:</b>	11/13/2014	<b>Date of Injury:</b>	08/07/2008
<b>Decision Date:</b>	12/30/2014	<b>UR Denial Date:</b>	10/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/07/2014

### 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. The expert reviewer is Board Certified in Occupational Medicine, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 52-year-old male who has submitted a claim for failed back syndrome, hypogonadism secondary to chronic opiate use, depression, and lumbar radiculopathy associated with an industrial injury date of 8/7/2008. Medical records from 2011 to 2014 were reviewed. The patient complained of low back pain radiating to the right lower extremity rated 8/10 in severity. Physical therapy and stretching had provided some relief. Aggravating factors included prolonged sitting and standing. The patient had symptoms of persistent depression. Physical examination of the lumbar spine showed tenderness, hypertonicity, limited motion, and negative straight leg raise test. Mental status examination showed an alert, oriented, and coherent patient. Mood was calm and participative. Speech was clear without sedation. Treatment to date has included lumbar laminectomy, physical therapy, Trazodone (since April 2014), Norco, Lyrica, Cymbalta, and ibuprofen. The utilization review from 10/19/2014 modified the request for physical therapy 2x8 for low back into physical therapy twice a week for a period of three weeks, a total of six sessions to provide a home exercise therapy education program; and modified the request for Trazodone 100mg #60 with 3 refills into Trazodone 100mg, #60 with one refill to allow more time for regular assessment of the patient's progress.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 2x8 For Low Back:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** As stated on pages 98-99 of the California MTUS Chronic Pain Medical Treatment Guidelines, physical medicine is recommended and that given frequency should be tapered and transition into a self-directed home program. In this case, the patient complained of low back pain radiating to the right lower extremity rated 8/10 in severity. Aggravating factors included prolonged sitting and standing. Physical examination of the lumbar spine showed tenderness, hypertonicity, limited motion, and negative straight leg raise test. Physical therapy and stretching had provided some relief. However, there is no objective evidence of overall pain improvement and functional gains derived from the treatment. Given the duration of injury, it is unclear why patient is still not versed to home exercise program to address the residual deficits. Moreover, there are no recent reports of acute exacerbation or progression of symptoms that would warrant additional course of treatment. The medical necessity has not been established. Therefore, the request for physical therapy 2x8 for low back is not medically necessary.

**Trazodone 100mg #60 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines regarding : Trazodone Page(s): 15.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain Page(s): 13-14. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress Section, Trazodone

**Decision rationale:** As stated on page 14 of CA MTUS Chronic Pain Medical Treatment Guidelines, tricyclic antidepressants are recommended as a first-line option for neuropathic pain, especially if pain is accompanied by insomnia, anxiety, or depression. ODG states that Trazodone is recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression, or anxiety. There is limited evidence to support its use for insomnia, but it may be an option in patients with coexisting depression. Patient is a diagnosed case of depression. He has been prescribed Trazodone since April 2014. However, there is no documentation concerning pain relief and functional improvement derived from its use. Moreover, there is no discussion why three refills should be certified at this time. Frequent monitoring of patient's response to current treatment regimen is paramount in managing chronic pain conditions. Therefore, the request for Trazodone 100mg #60 with 3 refills is not medically necessary.