MAXIMUS Federal Services

Case Number:	CM14-0205518		
Date Assigned:	01/23/2015	Date of Injury:	03/20/2014
Decision Date:	02/24/2015	UR Denial Date:	11/10/2014
Priority:	Standard	Application Received:	12/08/2014

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. 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 patient is a 41-year-old man who sustained a work-related injury on March 2, 2014. Subsequently, he developed chronic mid back, low back, and leg pain. The patient received epidural steroid injection on April 16, 2014 with no relief. He underwent right L4-L5 microdiscectomy performed on June 18, 2014, which did not provide any relief. He attended physical therapy every 2 weeks, which provided him moderate relief. According to a progress report dated December 29, 2014, the patient complained of pain in the mid back, lower back, right knee, right ankle, and right foot with radiation to the right leg. The pain was associated with tingling in the right leg and right foot, numbness in the bilateral hand and right leg, and weakness in the right leg. The pain was constant in frequency and severe in intensity. The patient rated the severity of the pain as a 6/10 at it best and 10/10 at its worst. He described the pain as spasm like with muscle pain, pins and needles sensation, and cold abnormal swelling. The pain in his back was 70% of his pain and the pain in his leg was 60% of his pain. Examination of the lumbar spine revealed range of motion to forward flexion was 30 degrees, extension was 5 degrees, and side bending was 10 degrees to the right and to the left. Rotation was limited. Inspection of the lumbar spine revealed normal alignment. There was tenderness to palpation over the bilateral lumbar paraspinal muscles consistent with spasms. There was positive lumbar facet loading maneuver bilaterally. There was positive straight leg raise test on the right in the seated and supine position to 15 degrees. Atrophy was noted in the right extensor hallucis longus, tibial anterior, and perineal musculature. Motor strength was 5/5 and symmetric throughout the bilateral lower extremities, except 4/5 on right knee extension, 2/5 on right ankle dorsiflexion,

right ankle plantarflexion, and right intrinsic hand musculature, and 1/5 on right great toe extension. There was diminished sensation in the left L5 and S1 dermatomes of the lower extremities. Reflexes were symmetric at 1+/4 in the bilateral lower extremities. There was negative bilateral Hoffmann's on the right, negative Babinski and negative Clonus signs. A UDS collected on October 10, 2014 was positive for hydrocodone and norhydrocodone. The patient was diagnosed with low back pain, radiculitis, postlaminectomy syndrome, lumbago, and displacement of lumbar intervertebral disc without myelopathy. The provider requested authorization for Trazadon, Methyl Salicylate15%, and physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazadon 50mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stree Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: 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 treatement with Trazodone. In addition, there is no recent documentation of insomnia. There is no documentation of failure of first line treatments for insomnia and depression. Therefore, the request for Trazodone 50mg is not medically necessary.

Methyl Salicylate15%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. That is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended. Furthermore, there is no documentation of the patient's intolerance of oral anti-inflammatory medications. Based on the above, Methyl Salicylate15% is not medically necessary.

Physical Therapy 2 x 6 weeks for 6 weeks: 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 Physical Medicine Page(s): 98.

Decision rationale: According to MTUS guidelines, Physical Medicine is <Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain,inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices.(Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007)>.There is no documentation of objective findings that the patient condition needed physical therapy. The patient underwent several physical therapy sessions without documentation of clear benefit. Therefore 2x6 weeks of Physical Therapy is not medically necessary.