MAXIMUS Federal Services

Case Number:	CM15-0139789		
Date Assigned:	07/29/2015	Date of Injury:	10/25/2000
Decision Date:	09/16/2015	UR Denial Date:	06/23/2015
Priority:	Standard	Application Received:	07/20/2015

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: Physical Medicine & Rehabilitation, Pain Management

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 59 year old female who sustained an industrial injury on 10/25/2000. Mechanism of injury occurred when she was moving her desk with the help of a custodian and twisted and felt immediate pain in the lower back and pain down the right lower extremity to the knee level. Diagnoses include post laminectomy syndrome and neuropathic pain with significant radiculopathy and restless legs, myofascial pain syndrome. Treatment to date has included diagnostic studies, medications, status post lumbar fusion, physical therapy, aquatic therapy, acupuncture and yoga. Medications include Neurontin and Norco, Effexor, Trazadone and Xanax. A physician progress note dated 05/26/2015 documents the injured worker continues to have right lower back pain. These medications allow her to function and perform her hygiene duties. They provide her with 30% pain relief. She is being considered for a spinal cord stimulator. On examination there is tenderness noted in the right lumbar and sacroiliac joint. Straight leg raise was positive on the right. Motor strength is the right lower extremity was reported to be 3 out of 5. She rates her pain as the least a 6 on the scale of 0 to 10. There is palpable twitch positive trigger points noted in the lumbar paraspinous muscles. She walks with an antalgic gait. There is tenderness over the greater trochanteric bursa on the right side. Treatment requested is for Effexor XR 150mg #30 with 2 refills, Effexor XR 75mg #30 with 2 refills, Trazodone 50mg #60 with 2 refills, and Xanax 5mg #30 with 2 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Effexor XR 150mg #30 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Venlafaxine (Effexor).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13-16.

Decision rationale: Regarding the request for venlafaxine (Effexor), 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. Within the documentation available for review, there is no identification that the Effexor provides any specific analgesic effect (in terms of reduced numeric rating scale or percent reduction in pain), or provides any objective functional improvement, reduction in opiate medication use, or improvement in psychological well-being. The requesting provider does document improvement in pain score with the entire pain regimen. However, it is noted that the recent progress notes fail to list Effexor in the medication list, and thus is unclear whether this is truly reducing pain. Given this, this request is not medically necessary.

Effexor XR 75mg #30 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Venlafaxine (Effexor).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13-16.

Decision rationale: Regarding the request for venlafaxine (Effexor), 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. Within the documentation available for review, there is no identification that the Effexor provides any specific analgesic effect (in terms of reduced numeric rating scale or percent reduction in pain), or provides any objective functional improvement, reduction in opiate medication use, or improvement in psychological well-being. The requesting provider does document improvement in pain score with the entire pain regimen. However, it is noted that the recent progress notes fail to list Effexor in the medication list, and thus is unclear whether this is truly reducing pain. Given this, this request is not medically necessary.

Trazodone 50mg #60 with 2 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Mental Illness & Stress - Online Version, Trazodone (Desyrel).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Sleep Medications.

Decision rationale: Regarding the request for trazodone, this drug is a serotonin reuptake inhibitor and can be utilized for many indications. In the records, it is not apparent whether this drug is being utilized to address depression, pain, or insomnia. The California MTUS guidelines have general guidelines for the use of antidepressants for pain, but are silent regarding the use of trazodone for insomnia management. The ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. The guidelines further stipulate that failure of sleep disturbances to resolve in 7 to 10 days may indicate a psychiatric or medical illness. There is a recommendation for non-pharmacologic modalities to address insomnia including education on sleep hygiene. 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 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 response to the medication in question. There is also no discussion with regard to whether this is being utilized for depression and its efficacy for this. Given this, the current request is not medically necessary.

Xanax 5mg #30 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: Regarding this request for a benzodiazepine, the Chronic Pain Medical Treatment Guidelines state the benzodiazepines are "Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. (Baillargeon, 2003) (Ashton, 2005)." Within the documentation available for review, it that the time frame for use is not appropriate. With this request, a 3-month supply is granted, but the guidelines do not recommend the continued use of Xanax beyond 4 weeks. Therefore, this request is not medically necessary. This medication should not be abruptly weaned, and the provider should be allowed to wean this medication as he or she sees fit. It is beyond the scope of the IMR process to dictate a particular weaning schedule.