

Case Number:	CM15-0162613		
Date Assigned:	08/28/2015	Date of Injury:	09/15/2009
Decision Date:	10/08/2015	UR Denial Date:	08/07/2015
Priority:	Standard	Application Received:	08/19/2015

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: Physical Medicine & Rehabilitation

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 31 year old male who sustained an industrial injury on 9-15-09 while lifting a beam he felt a pop in his back and had swelling in his right knee. Of note, the injured worker fell off of a ladder and landed on his back one month earlier and did not have medical treatment. He was medically evaluated for the 9-15-09 incident with x-rays of the right knee and low back and an MRI of the knee showing a meniscus tear. He currently complains of continued constant pain in the mid and lower back and right knee with radiation o the right leg with numbness, tingling and weakness in the right leg, just pain and tingling in the left; pain and numbness of shoulders, upper back, burning and finger tremors. His pain has been increasing since his injury and his pain level is 9 out of 10 without medications and 5 out of 10 with medications. On physical exam of the lumbar spine there was tenderness to palpation, sciatic notch tenderness, and positive facet loading maneuver bilaterally. Medications were tramadol, Effexor, gabapentin, omeprazole, trazadone, docuprene. Diagnoses include status post right knee surgery (9-2010); lumbar radiculitis; right knee meniscus tear, secondary right knee synovitis, effusion; chronic lumbar disc derangement, radiculitis; chronic pain syndrome; internal derangement of the knee; displacement of lumbar intervertebral disc without myelopathy. Treatments to date include knee injections and back injections with no long term relief; physical therapy to the knee and back; surgery of the right knee which worsened symptoms (2010); trigger point injections (2011 and 2012) without relief; chiropractic treatments; acupuncture without relief; psychological evaluation. Diagnostics include MRI of the right knee (2-8-10) showing meniscal tear; MRI of the lumbar spine (7-19-11)

unremarkable; MRI of the right knee (7-19-11) showing oblique tear of medial meniscus posterior horn. In the progress note dated 7- 27-15 the treating provider's plan of care includes requests for functional restoration program as he has failed all conservative treatment; Effexor ER 75 mg#30 with 3 refills; gabapentin 600mg for neuropathic pain; Trazadone 50mg #60 for sleep; Docuprene 100mg #60 for opioid constipation.

IMR ISSUES, DECISIONS AND RATIONALES

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

One functional restoration program (10 days): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Functional restoration programs (FRPs).

Decision rationale: The patient was injured on 09/15/09 and presents with mid back pain and low back pain with radiation to the right leg. The request is for One Functional Restoration Program (10 days). The RFA is dated 07/29/15 and the patient is permanent and stationary. The report with the request is not provided. MTUS guidelines page 49 recommends functional restoration programs and indicate it may be considered medically necessary when all criteria are met including: (1) adequate and thorough evaluation has been made; (2) Previous methods of treating chronic pain have been unsuccessful; (3) significant loss of ability to function independently resulting from the chronic pain; (4) not a candidate for surgery or other treatments would clearly be; (5) The patient exhibits motivation to change; (6) Negative predictors of success above have been addressed. MTUS page 49 also states that up to 80 hours or 2 week course is recommended first before allowing up to 160 hours when significant improvement has been demonstrated. The patient has tenderness to palpation along his lumbar spine, sciatic notch tenderness, and positive facet loading maneuver bilaterally. He is diagnosed with displacement of lumbar intervertebral disc without myelopathy, unspecified internal derangement of knee, and chronic pain syndrome. Treatments to date include knee injections and back injections with no long term relief; physical therapy to the knee and back; surgery of the right knee which worsened symptoms (2010); trigger point injections (2011 and 2012) without relief; chiropractic treatments; acupuncture without relief; psychological evaluation. The reason for the request is not provided, nor is there any documentation of any prior FRP the patient may have had. In this case, there is no thorough evaluation regarding the patient's candidacy for FRP. The negative predictors are not addressed as required by MTUS. The patient's secondary gain issues, motivation to change and improve, and any potential for surgical needs are not addressed. The requested Functional Restoration Program is not medically necessary.

Venlafaxine (Effexor) ER 75mg #30 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, under Effexor.

Decision rationale: The patient was injured on 09/15/09 and presents with mid back pain and low back pain with radiation to the right leg. The request is for Venlafaxine (Effexor) ER 75mg #30 with 2 refills. The RFA is dated 07/29/15 and the patient is permanent and stationary. The patient has been taking this medication as early as 01/06/15. ODG Guidelines, Pain chapter, under Effexor states, "Recommended as an option in first-line treatment of neuropathic pain. Venlafaxine - Effexor - is a member of the Selective serotonin and norepinephrine reuptake inhibitors," SNRIs- class of antidepressants. It has FDA approval for treatment of depression and anxiety disorders. It is off-label recommended for treatment of neuropathic pain, diabetic neuropathy, fibromyalgia, and headaches. MTUS Guidelines page 60 and 61 states that pain assessment and functional changes must also be noted when medications are used for chronic pain. The patient has tenderness to palpation along his lumbar spine, sciatic notch tenderness, and positive facet loading maneuver bilaterally. He is diagnosed with displacement of lumbar intervertebral disc without myelopathy, unspecified internal derangement of knee, and chronic pain syndrome. On 02/03/15 and 03/31/15, he rated his pain as a 9/10 without medication and a 5/10 with medication. "Pain alleviated with medications but for short time". The treater does not specifically discuss efficacy of Effexor on the reports provided. MTUS Guidelines page 60 states that when medications are used for chronic pain, recording of pain and function needs to be provided. Due to lack of documentation, the requested Effexor is not medically necessary.

Gabapentin 600mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: The patient was injured on 09/15/09 and presents with mid back pain and low back pain with radiation to the right leg. The request is for Gabapentin 600mg. The RFA is dated 07/29/15 and the patient is permanent and stationary. The patient has been taking this medication as early as 03/31/15. MTUS Guidelines, Gabapentin, pages 18 and 19 revealed the following: "Gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and post therapeutic neuralgia and has been considered a first-line treatment for neuropathic pain". MTUS page 60 also states, "A record of pain and function with the medication should be recorded", when medications are used for chronic pain. The patient has tenderness to palpation along his lumbar spine, sciatic notch tenderness, and positive facet loading maneuver bilaterally. He is diagnosed with displacement of lumbar intervertebral disc without myelopathy, unspecified internal derangement of knee, and chronic pain syndrome. On 03/31/15, he rated his pain as a 9/10 without medication and a 5/10 with medication. "Pain alleviated with medications but for short time". The treater does not specifically discuss efficacy of Gabapentin on the reports provided. MTUS Guidelines page 60 states that when medications

are used for chronic pain, recording of pain and function needs to be provided. Due to lack of documentation, the requested Gabapentin is not medically necessary.

Trazodone 50mg #60: 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), Pain (Chronic): Insomnia treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain.

Decision rationale: The patient was injured on 09/15/09 and presents with mid back pain and low back pain with radiation to the right leg. The request is for Trazodone 50mg #60 for sleep problems. The RFA is dated 07/29/15 and the patient is permanent and stationary. The patient has been taking this medication as early as 01/06/15. Regarding antidepressants, MTUS Guidelines pages 13-15, Chronic Pain Medical Treatment Guidelines: Antidepressants for chronic pain states, "Recommended as a first-line option for neuropathic pain, and has a possibility for non-neuropathic pain. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within few days to a week, whereas antidepressant effect takes longer to occur". Trazodone is also used for insomnia, and ODG supports it if insomnia and depression are documented. The patient has tenderness to palpation along his lumbar spine, sciatic notch tenderness, and positive facet loading maneuver bilaterally. He is diagnosed with displacement of lumbar intervertebral disc without myelopathy, unspecified internal derangement of knee, and chronic pain syndrome. On 03/31/15, he rated his pain as a 9/10 without medication and a 5/10 with medication. "Pain alleviated with medications but for short time". The treater does not specifically discuss efficacy of Trazodone on the reports provided. MTUS Guidelines page 60 states that when medications are used for chronic pain, recording of pain and function needs to be provided. Due to lack of documentation, the requested Trazodone is not medically necessary.