

<b>Case Number:</b>	CM13-0060740		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	09/19/2002
<b>Decision Date:</b>	07/31/2015	<b>UR Denial Date:</b>	11/05/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/03/2013

### 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, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative 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 (IW) is a 38-year-old male who sustained an industrial injury on 09/19/2002. Diagnoses include low back pain, status post fusion of L4 to S1 and followed by hardware removal; neck pain; depression. Treatment to date has included medications, spinal fusion and subsequent hardware removal, epidural steroid injections, home exercise and physical therapy. According to the progress notes dated 10/22/13, the IW reported he was not doing very well. One or two Norco per day was not sufficient for pain control and Lexapro made him drowsy all day. He complained of low back pain with numbness and tingling down both lower extremities--worse on the right. He also reported spasms and cramps in the low back and the legs, worse on the right. On examination, he wore a lumbar brace. The range of motion of the lumbar spine was reduced. Strength was fair in the bilateral lower extremities without myotomal pattern deficit. A request was made for Effexor XR 37.5mg as an alternative to Lexapro, due to the IW's sensitivity to antidepressant medications, and Zanaflex 4mg for spasms.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Effexor XR 37.5mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16. Decision based on Non-MTUS Citation ODG) Chronic Pain Chapter, Antidepressants for Chronic Pain, Venlafaxine (Effexor).

**Decision rationale:** Regarding the request for Effexor (venlafaxine), 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. ODG recommends venlafaxine as an option in first-line treatment of neuropathic pain. Venlafaxine 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. Guidelines indicate that a lack of response to antidepressant medications may indicate other underlying issues. 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. Also, the current request does not specify any quantified amount or duration for a trial and for regular monitoring. In the absence of clarity regarding those issues, the currently requested Effexor is not medically necessary.

**Zanaflex 4mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 63-66.

**Decision rationale:** Regarding the request for Tizanidine (Zanaflex), Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that Tizanidine specifically is FDA approved for management of spasticity; unlabeled use for low back pain. Guidelines recommend LFT monitoring at baseline 1, 3, and 6 months. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the Tizanidine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. Also, the current request does not specify any quantified amount or duration for a trial and for regular monitoring. Finally, it does not appear that there has been appropriate liver function testing, as recommended by guidelines. In the absence of such documentation, the currently requested Tizanidine (Zanaflex) is not medically necessary.