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| <b>Case Number:</b>   | CM15-0114650 |                              |            |
| <b>Date Assigned:</b> | 06/22/2015   | <b>Date of Injury:</b>       | 06/25/2012 |
| <b>Decision Date:</b> | 08/21/2015   | <b>UR Denial Date:</b>       | 06/09/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 06/15/2015 |

### 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: New York, Tennessee

Certification(s)/Specialty: Emergency 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 is a 44-year-old male, who sustained an industrial injury on 6/25/12. He reported initial complaints of lumbar spine, right knee and right shoulder injury. The injured worker was diagnosed as having muscle spasm; shoulder pain; low back pain; knee pain. Treatment to date has included right knee arthroscopy (2013); aquatic therapy; physical therapy; urine drug screening; medications. Diagnostics included EMG-NC study right lower extremity (no date/no report); MRI lumbar spine (10/28/14); MRI right knee (10/28/14). Currently, the PR- 2 notes dated 5/28/15 indicated the injured worker complains of low backache and right shoulder pain and right knee pain. He rates his pain with medications as 5-10 and without medications 8- 10.He has no new problems or side-effects and his quality of sleep is noted as poor. Hi activity level remains unchanged; taking his medications as prescribed and they are working well for him. He reports left knee pain since March 2015 secondary to using it or offload the right knee and requesting the left knee now be treated. Medications are listed by the provider as: Neurotin, Voltaren 1% gel, Zanaflex, Ultram, Acetadryl, diclofenac and Xanax. On physical examination, the provider notes the injured worker appears to be in mild pain. He has a right-sided antalgic gait described as slow, wide-based and assisted by a cane. His lumbar spine exam notes restricted range of motion limited by pain He cannot heel-toe walk. Gaenslen's is negative. Lumbar facet loading is negative bilaterally. Stretch of the piriformis was negative as well as straight leg raise and Faber's. Right shoulder examination noted movements restricted due to pain. Hawkin's, Neer's testing were positive with shoulder crossover test negative. Speed's, Yergason's and Popeye's sing are negative ruling out any biceps pathology. Drop arm test is negative. There are no limitations on the left shoulder examination. The right knee range of motion is restricted by pain. Tenderness to palpation is noted over the lateral joint line and medial joint line. The right knee is stable to valgus stress in extension and at 30 degrees. The right knee is stable to varus stress in extension and at 30 degrees. Negative anterior drawer, 1A

Lachman test and negative pivot shift test. Negative posterior drawer test and reverse pivot shift test. Mild effusion is noted in the right knee joint. McMurry's test is positive. Bounce test is positive. There are no limitations noted of the left knee. The treatment plan includes waiting for authorization of a right knee brace, left knee x-ray, psych consultation; aquatic therapy. The provider is also requesting medications to continue without change: Neurotin 300mg #30; Trazadone 50mg #30; Ultram 50mg #60 and Voltaren 1% (unspecified quantity).

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Trazadone 50mg #30: 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).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Insomnia Treatment.

**Decision rationale:** Trazodone is a tetracyclic antidepressant usually prescribed for insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. Insomnia treatment should be based on etiology. Most medications have only been evaluated for short term use (less than 4 weeks). Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Sedating antidepressants are often used to treat insomnia; however, there is less evidence to support their use for insomnia. They may be an option in patients with coexisting depression. Trazodone is one of the most commonly prescribed agents for insomnia. Side effects of this drug include nausea, dry mouth, constipation, drowsiness, and headache. Negative next-day effects such as ease of awakening may offset improvements in sleep onset. Tolerance may develop and rebound insomnia has been found after discontinuation. In this case prior treatment for insomnia with trazodone was ineffective. Lack of past success is an indicator that future success is unlikely. The request is not medically necessary.

#### **Ultram 50mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78, 80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 74-96.

**Decision rationale:** Ultram is the medication tramadol. Tramadol is a synthetic opioid affecting the central nervous system. It has several side effects, which include increasing the risk of seizure in patients taking SSRIs, TCAs and other opioids. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional

goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain or function. It is recommended for short-term use if first-line options, such as acetaminophen or NSAIDs have failed. In this case, the patient has been receiving ultram since at least November 2014 and has not obtained analgesia. In addition there is no documentation that the patient has signed an opioid contract. Criteria for long-term opioid use have not been met. The request is not medically necessary.

**Neurontin 300mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 17.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 18-19.

**Decision rationale:** Gabapentin is an anti-epileptic medication. Gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain and has FDA approval for treatment of post-herpetic neuralgia. Gabapentin appears to be effective in reducing abnormal hypersensitivity, to have anti-anxiety effects, and may be beneficial as a sleep aid. Gabapentin has a favorable side-effect profile, few clinically significant drug-drug interactions and is generally well tolerated; however, common side effects include dizziness, somnolence, confusion, ataxia, peripheral edema, dry mouth, and weight gain. It has been recommended for the treatment of pain from spinal cord injury, fibromyalgia, lumbar spinal stenosis, and chronic regional pain syndrome. Recommended trial period is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. If inadequate control of pain is found, a switch to another first-line drug is recommended. In this case, the patient has been receiving gabapentin since at least November 2014 and has not obtained analgesia. Another first line medication is recommended if the gabapentin is ineffective. The request is not medically necessary.

**Voltaren 1% (unspecified quantity):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Diclofenac.

**Decision rationale:** Voltaren gel is the topical non-steroidal anti-inflammatory drug (NSAID) diclofenac. Topical NSAIDs have been shown to be superior to placebo in the treatment of osteoarthritis, but only in the short term and not for extended treatment. The effect appears to diminish over time. Absorption of the medication can occur and may have systemic side effects comparable to oral form. It is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. In this case, documentation in the medical record does not support the diagnosis of osteoarthritis. There is no medical indication for the use of voltaren gel. The request is not medically necessary.