

<b>Case Number:</b>	CM15-0123023		
<b>Date Assigned:</b>	07/07/2015	<b>Date of Injury:</b>	06/05/2001
<b>Decision Date:</b>	09/22/2015	<b>UR Denial Date:</b>	06/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/26/2015

### 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: Indiana

Certification(s)/Specialty: Preventive Medicine, Occupational 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 57 year old male, who sustained an industrial injury on 6/5/01. The diagnoses have included internal derangement of the right and left knees, discogenic lumbar condition, impingement syndrome bilaterally epicondylitis medially bilaterally and wrist joint inflammation with numbness along the fingers. Treatment to date has included medications, activity modifications, off of work, hot and cold wrap, elbow sleeve, bracing, diagnostics, Transcutaneous electrical nerve stimulation (TENS), bracing, consultation, knee injections, acupuncture, and chiropractic sessions. Currently, as per the physician progress note dated 4/20/15, the injured worker complains of bilateral shoulder pain, bilateral elbow pain, bilateral wrist pain, low back pain, bilateral knee pain and neck pain. He complains of persistent neck and low back pain and states that the pain is worsening. The objective findings reveal cervical and lumbar tenderness, pain along the facets and pain with facet loading. He also has had a weight gain of 15 pounds. The current medications included Ultracet, Protonix, and Naproxen. There is no previous urine drug screen reports noted in the records. The physician requested treatments included Effexor extended release 75mg #60, Trazodone 50mg #60, Neurontin 600mg #90, Norflex 100mg #60, Transcutaneous electrical nerve stimulation (TENS) pads for two lead TENS unit, and Right elbow pad.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Effexor extended release 75mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-14. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), pain chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain interventions and treatments Page(s): 16-17.

**Decision rationale:** Venlafaxine is classified as a serotonin and norepinephrine reuptake inhibitor, commonly used as an antidepressant. MTUS state regarding antidepressants for pain, "Recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. (Feuerstein, 1997) (Perrot, 2006) Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur." MTUS further details "Venlafaxine (Effexor): FDA-approved for anxiety, depression, panic disorder and social phobias. Off-label use for fibromyalgia, neuropathic pain, and diabetic neuropathy." And Dosing: Neuropathic pain (off-label indication): 37.5 mg once daily, increase by 37.5 mg per week up to 300 mg daily. (Maizels, 2005) (ICSI, 2007) Trial period: Some relief may occur in first two weeks; full benefit may not occur until six weeks. Withdrawal effects can be severe. Abrupt discontinuation should be avoided and tapering is recommended before discontinuation." The treating physician does not indicate failure of first-line agents and does not indicate how a first line agent is ineffective, poorly tolerated, or contraindicated. As such, the request for Venlafaxine 75mg #60 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), mental illness and stress chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress, Trazodone.

**Decision rationale:** Regarding Trazodone, the above-cited guidelines say: "Recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. See also Insomnia treatment, where it says there is limited evidence to support its use for insomnia, but it may be an option in patients with coexisting depression. The current recommendation is to utilize a combined pharmacologic and psychological and behavior treatment when primary insomnia is diagnosed. Also worth noting, there has been no dose-finding study performed to assess the dose of Trazodone for insomnia in non-depressed patients. Other pharmacologic therapies should be recommended for primary insomnia before considering Trazodone, especially if the insomnia is not accompanied by comorbid depression or recurrent treatment failure. There is no clear-cut evidence to recommend

Trazodone first line to treat primary insomnia." There is no documentation of co-existing psychiatric symptoms and there is no discussion of failure of first line therapies or counseling on sleep hygiene. Therefore, the request is not medically necessary.

**Neurontin 600mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-17.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs Page(s): 16-22. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Anti-epilepsy drugs (AEDs) for pain, Gabapentin (Neurontin).

**Decision rationale:** The MTUS considers Gabapentin as a first-line treatment for neuropathic pain and effective for the treatment of spinal cord injury, lumbar spinal stenosis, and post op pain. MTUS also recommends a trial of Gabapentin for complex regional pain syndrome. ODG states "Recommended Trial Period: One recommendation for an adequate trial with Gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. (Dworkin, 2003) The patient should be asked at each visit as to whether there has been a change in pain or function. Current consensus based treatment algorithms for diabetic neuropathy suggests that if inadequate control of pain is found, a switch to another first-line drug is recommended." Additionally, ODG states that 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". Based on the clinical documentation provided, there is no evidence of neuropathic type pain or radicular pain on exam or subjectively. As such, without any evidence of neuropathic type pain, the medication is not medically necessary.

**Norflex 100mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-65.

**Decision rationale:** Norflex is classified as a muscle relaxant. MTUS states, "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement." ODG recommends limited muscle relaxant usage to 2 weeks in duration. Additionally, MTUS states "Orphenadrine (Norflex, Banflex, Antiflex", Mio-Rel, Orphenate, generic available): This drug is similar to diphenhydramine, but has greater anticholinergic effects. The mode of action is not clearly understood. Effects are thought to be secondary to analgesic and anticholinergic properties. This drug was approved by the FDA in 1959. Side Effects: Anticholinergic effects (drowsiness, urinary retention, dry

mouth). Side effects may limit use in the elderly. This medication has been reported in case studies to be abused for euphoria and to have mood-elevating effects. (Shariatmadari, 1975) Dosing: 100 mg twice a day; combination products are given three to four times a day. (See, 2008). MTUS guidelines recommend against the long-term use of muscle relaxants. The patient has been on this muscle relaxant at least several months. Guidelines recommend against long-term muscle relaxant usage. The treating physician has not detailed how NSAIDs is inferior to Norflex, per MTUS guidelines. As written, the prescription is for 60 days of medication, which is still in excess of the recommended 2-week limit. The medical documents do not indicate extenuating circumstances to allow for exceptions to the guidelines. As such, the request is not medically necessary.

**TENS pads for two lead TENS unit: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-116.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back: Durable Medical Equipment and Other Medical Treatment Guidelines Medicare.gov, durable medical equipment.

**Decision rationale:** MTUS and ACOEM are silent regarding the medical necessity of TENS pad or patches, but does address TENS unit. ODG does state regarding durable medical equipment (DME), "Recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME) below" and further details "Exercise equipment is considered not primarily medical in nature". Medicare details DME as: durable and can withstand repeated use; used for a medical reason; not usually useful to someone who isn't sick or injured; appropriate to be used in your home. While TENS pads do meet criteria as durable medical equipment, the medical notes do not establish benefit from ongoing usage of a TENS unit. The treating physician does not include objective or subjective findings to substantiate if the TENS unit is improving the employee's pain or function. Given lack of documented improvement, the continued usage of TENS does not appear to be indicated and therefore the associated patches also do not appear to be indicated. As such, the request is not medically necessary.

**Right elbow pad: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), elbow chapter, splinting.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow: Splinting (Padding).

**Decision rationale:** MTUS is silent regarding elbow pads, but ODG states the following: "Recommended for cubital tunnel syndrome (ulnar nerve entrapment), including a splint or foam elbow pad worn at night (to limit movement and reduce irritation), and/or an elbow pad (to protect against chronic irritation from hard surfaces). (Apfel, 2006) (Hong, 1996) Under study for epicondylitis. No definitive conclusions can be drawn concerning effectiveness of standard braces or splints for lateral epicondylitis. (Borkholder, 2004) (Derebery, 2005) (Van De Streek, 2004) (Jensen, 2001) (Struijs, 2001) (Jansen, 1997) If used, bracing or splinting is recommended only as short-term initial treatment for lateral epicondylitis in combination with physical therapy. (Struijs, 2004) (Struijs, 2006) Some positive results have been seen with the development of a new dynamic extensor brace but more trials need to be conducted. Initial results show significant pain reduction, improved functionality of the arm, and improvement in pain-free grip strength. The beneficial effects of the dynamic extensor brace observed after 12 weeks were significantly different from the treatment group that received no brace. The beneficial effects were sustained for another 12 weeks. (Faes, 2006) (Faes2, 2006) Static progressive splinting can help gain additional motion when standard exercises seem stagnant or inadequate, particularly after the original injury. Operative treatment of stiffness was avoided in most patients. (Doornberg, 2006) These results differ from studies testing standard bracing which showed little to no effect on pain." The medical documentation does not show the employee has lateral epicondylitis and is currently not using the elbow sleeve. It is unclear what the justification for an elbow pad is and how that fits into the ongoing treatment plan. Therefore, the request is not medically necessary.