

<b>Case Number:</b>	CM15-0090631		
<b>Date Assigned:</b>	05/14/2015	<b>Date of Injury:</b>	08/30/2011
<b>Decision Date:</b>	08/18/2015	<b>UR Denial Date:</b>	04/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/11/2015

### 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: Georgia

Certification(s)/Specialty: Anesthesiology, 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 year old female, who sustained an industrial injury on 08/03/2011. Initial complaints and diagnosis were not clearly documented. On provider visit dated 02/13/2015 the injured worker has reported ongoing neck, back pain and bilateral upper and lower extremity pain. On examination tenderness to cervical and lumbar paraspinal muscle. Tenderness of the left wrist and hand, and tenderness to the right knee was noted. The diagnoses have included neck and left upper extremity pain, low back and right lower extremity pain, bilateral shoulder pain, and bilateral knee pain. The injured worker work status was notes as no lifting, pushing, pulling great than 20 pounds and no frequent bedding, stooping, prolonged sitting or standing. Treatment to date has included current medication: Norco, Voltaren gel, Tizanidine, Effexor, Lactulose solution, Cymbalta, Silenor and Ambien. The provider requested retrospective review for date of service (DOS) 03/13/15 for pharmacy purchase of remaining Norco (Hydrocodone/ Acetaminophen) 10/325mg #120, retrospective review for date of service (DOS) 03/13/15 Effexor (venlafaxine) 75mg #60, retrospective review for date of service (DOS) 03/13/15 for pharmacy purchase of Zanaflex (Tizanidine) 4mg #60, and retrospective review for date of service (DOS) 03/13/15 for pharmacy purchase of Ambien (Zolpidem) 5mg #30.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective review for date of service (DOS) 03/13/15 for pharmacy purchase of remaining Norco (Hydrocodone/Acetaminophen) 10/325mg #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79.

**Decision rationale:** Retrospective review for date of service (DOS) 03/13/15 for pharmacy purchase of remaining Norco (Hydrocodone/Acetaminophen) 10/325mg #120 is not medically necessary. Per MTUS Page 79 of MTUS guidelines states that weaning of opioids are recommended if (a) there are no overall improvement in function, unless there are extenuating circumstances (b) continuing pain with evidence of intolerable adverse effects (c) decrease in functioning (d) resolution of pain (e) if serious non-adherence is occurring (f) the patient requests discontinuing. The claimant's medical records did not document that there was an overall improvement in function or a return to work with previous opioid therapy. The claimant has long-term use with this medication and there was a lack of improved function with this opioid; therefore, requested medication is not medically necessary.

**Retrospective review for date of service (DOS) 03/13/15 Effexor (venlafaxine) 75mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants for chronic pain Page(s): 13-16.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants Page(s): 12-13.

**Decision rationale:** Retrospective review for date of service (DOS) 03/13/15 Effexor (venlafaxine) 75mg #60 is not medically necessary. Ca MTUS page 13 states that antidepressants are recommended as first-line option for neuropathic pain, as a possibility for non-neuropathic pain. Tricyclics are generally considered first line agent unless they're ineffective, poorly tolerated, or contraindicated. Effexor is a serotonin and norepinephrine reuptake inhibitor. Per Ca MTUS SNRIs is a class of anti-depressants that inhibit serotonin and noradrenaline reuptake. These medications are controversial based on controlled trials. It is been suggested that the main role of SNRIs may be in addressing psychological symptoms associated with chronic pain. More information is needed regarding the role of SNRIs and pain. The medical records do not appropriately address whether the claimant has depression associated with chronic pain through psychological evaluation. Additionally there was no documentation that the enrollee failed Tricyclics which is recommended by Ca MTUS as first line therapy.

**Retrospective review for date of service (DOS) 03/13/15 for pharmacy purchase of Ambien (Zolpidem) 5mg #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), Zolpidem (Ambien).

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

**Decision rationale:** Retrospective review for date of service (DOS) 03/13/15 for pharmacy purchase of Ambien (Zolpidem) 5mg #30 is not medically necessary. The ODG states that Ambien is not recommended for long term use, but recommended for short-term use. While sleeping pills, so called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialist rarely, if ever, recommend them for long-term use. They can be habit-forming and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over long-term. Ambien is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. Longer-term studies have found Ambien to be effective for up to 24 weeks in adults. According to the medical records it is unclear how long the claimant was on the sleeping aid medication of this class. Additionally, there is no documentation of sleep disorder requiring this medication. It is more appropriate to set a weaning protocol at this point. Ambien 5mg # 30 is not medically necessary.

**Retrospective review for date of service (DOS) 03/13/15 for pharmacy purchase of Zanaflex (Tizanidine) 4mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 64-66.

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

**Decision rationale:** Retrospective review for date of service (DOS) 03/13/15 for pharmacy purchase of Zanaflex (Tizanidine) 4mg #60 is not medically necessary. Tizanidine (Zanaflex, generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. (Malanga, 2008) Eight studies have demonstrated efficacy for low back pain. (Chou, 2007) One study (conducted only in females) demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain. (Malanga, 2002) May also provide benefit as an adjunct treatment for fibromyalgia. (ICSI, 2007) The recommended dosing is 4mg with a max dose of 36 mg per day. The medical records indicate that the zanaflex was prescribed for back pain. MTUS recommends short term use for myofascial pain or fibromyalgia; therefore, the claim is not medically necessary.