

<b>Case Number:</b>	CM15-0092406		
<b>Date Assigned:</b>	05/18/2015	<b>Date of Injury:</b>	09/17/2010
<b>Decision Date:</b>	06/24/2015	<b>UR Denial Date:</b>	05/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/13/2015

### 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: Pennsylvania  
 Certification(s)/Specialty: Internal 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 56 year old female who sustained an industrial injury on September 17, 2010. She reported slipping and falling backwards with immediate pain in the left elbow, left shoulder, lower back, buttocks, and hands. The injured worker was diagnosed as having cervical spine large disc herniation at C5-C6 with left sided radiculopathy noted on the electro-myography (EMG), left shoulder full thickness rotator cuff tear, left elbow cubital tunnel syndrome status post cubital tunnel release in 2014 with continued symptoms and tear of the common extensor tendons possibly requiring surgery in the future, right elbow lateral epicondylitis and concern for cubital tunnel syndrome, right wrist carpal tunnel syndrome status post release with continued symptoms, left wrist carpal tunnel syndrome status post release with continued symptoms, lumbar spine fusion L4-L5 and L5-S1 with some continued pain and weakness, bilateral thumb trigger finger resolved with single injection, and significant pain management needs. Additional diagnoses include major depressive disorder, pain disorder, and insomnia. Treatment and evaluation to date has included cortisone injections to the shoulder, x-rays, MRIs, electro-diagnostic studies, physical therapy, wrist supports, home exercise program (HEP), carpal tunnel release, trigger point injections, lower back surgery, and medication. An Agreed Medical Examination in June of 2013 and an orthopedic evaluation in January 2015 noted that the injured worker had not been employed since June 2011. Medications in 2013 included bupropion, carisoprodol, hydrocodone/acetaminophen, hydroxyzine, quetiapine, trazodone, clonazepam, omeprazole, ultram, and flector patches. A urine drug screen on 7/22/14 was positive for lorazepam, oxycodone, and oxymorphone. Currently, the injured worker complains of constant cervical pain, developing headaches, numbness and tingling in her

hands, left shoulder constant pain radiating to her hand, bilateral elbow constant pain with soreness, weakness, numbness, and tingling radiating to her hands, intermittent right wrist pain, constant left wrist pain, lumbar spine constant pain radiating to her buttocks, sudden changes in mood, decreased appetite, anxiety, and depression. The Primary Treating Physician's report dated January 12, 2015, listed the injured worker's current medications as Gabapentin, Oxycodone, oxycontin, Trazodone, Venlafaxine, Ativan, and Pantoprazole. Physical examination showed spasms at L3-S1, and positive bilateral straight leg raise, and normal lower extremity strength and sensation. The left shoulder was noted to have pain in the impingement area. The injured worker was noted to have failed conservative treatments, with surgery requested and authorized for the left shoulder. The treatment plan included requests for authorization for continued treatment with a pain management specialist, continued treatment with a spine specialist, an updated MRI of the left shoulder, postoperative physical therapy, postoperative medications, and bilateral upper extremity electromyography (EMG), and urine toxicology. Work status was noted as temporarily totally disabled. In February 2015, medications were noted to include oxycontin, oxycodone, Ativan, trazodone, gabapentin, Effexor, and DOSS (docusate). Treatment at a psychiatric center in 2012 was documented. It was noted that the injured worker uses medication to sleep almost daily, with multiple awakenings at night and 2-3 hours of sleep a night. On 5/5/15, Utilization Review (UR) non-certified requests for the items currently under Independent Medical Review, citing the MTUS and ODG.

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

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

**Ativan 2mg, #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines benzodiazepines p. 24 muscle relaxants p. 66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter: benzodiazepines.

**Decision rationale:** This injured worker has diagnoses of depression and insomnia, with complaint of anxiety. Benzodiazepines have been prescribed for more than one year. Per the MTUS, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long term use may actually increase anxiety. The MTUS states that a more appropriate treatment for anxiety disorder is an antidepressant. The MTUS does not recommend benzodiazepines for long term use for any condition. The MTUS does not recommend benzodiazepines as muscle relaxants. The Official Disability Guidelines recommend against prescribing benzodiazepines with opioids and other sedatives. This injured worker has also been prescribed oxycodone, an opioid medication. Due to length of use in excess of the guideline recommendations and concurrent use of opioid medication, the request for ativan is not medically necessary.

**Trazadone 150mg, #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) Mental Illness & Stress Chapter, Online Version.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines antidepressants Page(s): 13-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) chronic pain chapter: insomnia treatment.

**Decision rationale:** This injured worker has multiple diagnoses as noted above, including chronic pain, depression, and insomnia. Trazodone was prescribed in 2013 and was listed among current medications in January and February 2015. The reason for prescription of trazodone was not discussed by the treating physician. Trazodone is a tetracyclic antidepressant used to treat depression and anxiety disorders. Per the MTUS, antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain, unless they are poorly tolerated, contraindicated, or ineffective. 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. This injured worker has not worked since 2011 and current work status was noted as temporarily totally disabled. There was no discussion of improvement in activities of daily living. Psychiatric treatment in 2012 was noted, but there was no discussion of current psychological evaluation and no recent detailed psychiatric examination. Sedating antidepressants such as amitriptyline, trazodone, and mirtazapine have been used to treat insomnia; there is less evidence to support their use for insomnia but 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. Improvements in sleep onset may be offset by negative next-day effects such as ease of awakening. Tolerance may develop and rebound insomnia has been found after discontinuation. The MTUS does not address the use of hypnotics other than benzodiazepines. No physician reports describe the specific criteria for a sleep disorder. Treatment of a sleep disorder, including prescribing hypnotics, should not be initiated without a careful diagnosis. There is no evidence of that in this case. For the treatment of insomnia, pharmacologic agents should only be used after careful evaluation of potential causes of sleep disturbance. Specific components of insomnia should be addressed. There was no documentation of evaluation of sleep disturbance in the injured worker, and components insomnia were not addressed. Due to lack of adequate evaluation for depression and sleep disorder, and lack of functional improvement, the request for trazodone is not medically necessary.

**Venlafaxine 37.5mg, #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Online Version.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 401-402, Chronic Pain Treatment Guidelines antidepressants p. 13-16, SNRIs p. 105, SSRIs p. 107, venlafaxine p. 123. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) mental illness and stress chapter: antidepressants for treatment of major depressive disorder.

**Decision rationale:** This injured worker has multiple diagnoses as noted above, including chronic pain, depression, and insomnia. The reason for prescription of venlafaxine was not discussed in the documentation submitted. The MTUS states that antidepressants are recommended as a first line option for neuropathic pain and as a possibility for non-neuropathic pain. 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. The ACOEM notes that brief courses of antidepressants may be helpful to alleviate symptoms of depression, but that given the complexity of available agents, referral for medication evaluation is advised. The ODG states that antidepressants offer significant benefit in the treatment of the severest depressive symptoms, but may have little or no therapeutic benefit over and above placebo in patients with mild to moderate depression. Venlafaxine (Effexor) is a selective serotonin and norepinephrine reuptake inhibitor (SNRI) which is FDA approved for treatment of depression and anxiety. It is recommended off-label for treatment of neuropathic pain, diabetic neuropathy, fibromyalgia, and headaches. The MTUS states that it is recommended as an option in first-line treatment of neuropathic pain. Dosage adjustments may be necessary in patients with hepatic and renal impairment. There was no documentation of laboratory testing of hepatic or renal function for this injured worker. Venlafaxine has been prescribed since at least January 2015. This injured worker has not worked since 2011 and current work status was noted as temporarily totally disabled. There was no discussion of improvement in activities of daily living. Psychiatric treatment in 2012 was noted, but there was no discussion of current psychological evaluation and no recent detailed psychiatric examination. Due to lack of documentation of specific indication, lack of current psychological evaluation, and lack of documentation of functional improvement, the request for venlafaxine is not medically necessary.

**Oxycodone 30mg, #150:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioid.

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

**Decision rationale:** This injured worker has chronic multifocal pain. Opioids have been prescribed for more than one year, since at least June of 2013. A urine drug screen in 2014 was positive for oxycodone, and oxycodone was documented to be prescribed in January and February 2015. There is insufficient evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. There was no discussion of functional goals. The documentation indicates that the injured worker has not

worked since June 2011. No opioid contract was discussed. One urine drug screen was submitted; it was not documented if the collection was random, and results were not discussed. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, "mechanical and compressive etiologies," and chronic back pain. There is no evidence of significant pain relief or increased function from the opioids used to date. The MTUS states that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient "has failed a trial of non-opioid analgesics." Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The documentation does not reflect improvement in pain. Change in activities of daily living, discussion of adverse side effects, and screening for aberrant drug-taking behaviors were not documented. The MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. There is no record of a urine drug screen program performed according to quality criteria in the MTUS and other guidelines. As currently prescribed, oxycodone does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

**Oxycodone 40mg, #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioid.

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

**Decision rationale:** This injured worker has chronic multifocal pain. Opioids have been prescribed for more than one year, since at least June of 2013. A urine drug screen in 2014 was positive for oxycodone, and oxycodone was documented to be prescribed in January and February 2015. There is insufficient evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. There was no discussion of functional goals. The documentation indicates that the injured worker has not worked since June 2011. No opioid contract was discussed. One urine drug screen was submitted; it was not documented if the collection was random, and results were not discussed. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, "mechanical and compressive etiologies," and chronic back pain. There is no evidence of significant pain relief or increased function from the opioids used to date. The MTUS states that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient "has failed a trial of non-opioid analgesics." Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The documentation does not reflect improvement in pain. Change in activities of daily living, discussion of adverse side effects, and screening for aberrant drug-taking behaviors were not documented. The MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. There is no record of a urine drug screen program performed according to quality criteria in the MTUS and other guidelines. As currently prescribed, oxycodone does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.