

Case Number:	CM14-0142423		
Date Assigned:	09/10/2014	Date of Injury:	04/16/2004
Decision Date:	10/15/2014	UR Denial Date:	08/08/2014
Priority:	Standard	Application Received:	09/03/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 45-year-old female who reported an injury on 04/16/2004 due to an unknown mechanism. The diagnoses were status post anterior cervical discectomy and fusion, C4-5 and C5-6, with painful restrained hardware and dysphasia; possible junctional pathology; cervical spine discopathy; status post anterior cervical spine hardware removal; right ankle fracture; and status post right ankle open reduction internal fixation surgery. The physical examination on 04/09/2014 revealed complaints of pain in the neck and upper extremities. The injured worker reported the pain an 8/10 on the pain scale. She complained of numbness, with a pins and needles like sensation, and rated that an 8/10. An examination of the cervical spine revealed tenderness in the paraspinous musculature. The range of motion for the cervical spine was slightly decreased. Sensation testing was normal. The medications were Zoloft, Wellbutrin, Norco, Soma, Robaxin, Ambien, Lorazepam, and Tizanidine. The treatment plan was to continue medications as directed. The rationale was not submitted. The Request for Authorization was submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Wellbutrin XL 150mg #30 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13.

Decision rationale: The request for Wellbutrin XL 150mg #30 with 3 refills is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend antidepressants as a first line medication for treatment of neuropathic pain, and they are recommended especially if pain is accompanied by insomnia, anxiety, or depression. There should be documentation of an objective decrease in pain and objective functional improvement to include an assessment in the changes in the use of other analgesic medications, sleep quality and duration, and psychological assessment. The efficacy of this medication was not reported. There was no documentation of an objective decrease pain and objective functional improvement reported. The request does not indicate a frequency for the medication. Therefore, this request is not medically necessary.

Ativan 1mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain, Benzodiazepines Page(s): 24.

Decision rationale: The request for Ativan 1mg #30 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines do not recommend benzodiazepines for long term use, and most guidelines limit use to 4 weeks. The efficacy of this medication was not reported. The request does not indicate a frequency for the medication. The clinical documentation submitted for review does provide evidence that the injured worker has been on this medication for an extended duration of time. Therefore, this request is not medically necessary.

Zoloft 100mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13.

Decision rationale: The request for Zoloft 100mg #60 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend antidepressants as a first line medication for treatment of neuropathic pain and they are recommended especially if pain is accompanied by insomnia, anxiety, or depression. There should be documentation of an objective decrease in pain and objective functional improvement to include an assessment in the changes in use of other analgesic medications, sleep quality and duration, and psychological assessment. There was no documentation of objective decrease in pain and objective functional improvement, sleep quality and duration, and or psychological assessment. The request does not

indicate a frequency for the medication. The clinical information submitted for review does not provide evidence to justify continued use. Therefore, this request is not medically necessary.

Ambien CR 12.5mg #30 with 3 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Chronic Pain

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

Decision rationale: The request for Ambien CR 12.5mg #30 with 3 refills is not medically necessary. The Official Disability Guidelines indicate zolpidem (Ambien) is appropriate for the short term treatment of insomnia, generally 2 to 6 weeks. The request does not indicate a frequency for the medication. The medical guidelines do not support the use longer than 2 to 6 weeks. The clinical documentation submitted for review does provide evidence that the injured worker has been on this medication for an extended duration of time. Therefore, this request is not medically necessary.

Neurontin 300mg #90 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 16.

Decision rationale: The request for Neurontin 300mg #90 with 3 refills is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that gabapentin is 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. The efficacy of this medication was not provided. The request does not indicate a frequency for the medication. Therefore, this request is not medically necessary.

Soma 350mg #120 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain, Carisoprodol Page(s): 29, 65.

Decision rationale: Soma 350mg #120 with 3 refills is not medically necessary. The California Medical Treatment Utilization Schedule states that Soma (carisoprodol) is not indicated for longer than 2 to 3 weeks. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant. It has been suggested that the main effect is due to generalized sedation and

treatment of anxiety. Abuse has been noted for sedative and relaxant effects. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs. A withdrawal syndrome has been documented that consists of insomnia, vomiting, tremors, muscle twitching, anxiety, and ataxia when abrupt discontinuation of large doses occurs. Tapering should be individualized for each patient. The efficacy of this medication was not reported. The request does not indicate a frequency for the medication. The clinical documentation submitted for review does provide evidence that the injured worker has been on this medication for an extended duration of time. Therefore, this request is not medically necessary.

Norco 10/325mg #180 with 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Norco, Ongoing Management Page(s): 78.

Decision rationale: The request for Norco 10/325mg #180 with 3 refills is not medically necessary. The California Medical Treatment Utilization Schedule recommends short acting opioids such as Norco for controlling chronic pain. For ongoing management, there should be documentation of the 4 A's including analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. The 4 A's of ongoing monitoring of an opioid medication were not reported. The request submitted does not indicate a frequency for the medication. Therefore, this request is not medically necessary.