

<b>Case Number:</b>	CM13-0020492		
<b>Date Assigned:</b>	10/11/2013	<b>Date of Injury:</b>	04/30/2003
<b>Decision Date:</b>	03/14/2014	<b>UR Denial Date:</b>	08/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/05/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and Cardiology, was Fellowship trained in Cardiovascular Disease, and is licensed to practice in Texas. 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 physician 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 patient is a 56-year-old female who reported an injury on 4/30/03 due to cumulative trauma while performing normal job duties that resulted in a neck injury and bilateral upper extremity pain. The patient was initially treated conservatively with physical therapy and eventually underwent bilateral carpal tunnel release. In addition to the patient's prior surgical intervention, the patient also received medications, epidural steroid injections, and psychological support. The patient received psychotropic medications to include Clonazepam, Lamotrigine, topiramate, Trazodone, and zolpidem. The most recent clinical examination findings included cool distal fingertips, decreased sensation along the dorsal web space with a positive Tinel's on the right, and suboccipital and intrascapular spasms. The patient's diagnoses included chronic pain syndrome, complex regional pain syndrome, sprain/strain of the cervical spine, and status post right thumb arthroplasty. The patient's psychiatric diagnoses included major depressive disorder, sleep disorder, and mixed personality disorder. The patient's treatment plan included continuation of medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**60 Clonazepam 1mg:** Upheld

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

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

**Decision rationale:** The California MTUS states that benzodiazepines are not recommended for long term use as long term efficacy is unproven, and there is risk of dependence or addiction. Guidelines limit use to four weeks. Although a short course of Clonazepam may benefit this patient, the requested 60 pills exceed the four week recommendation. The MTUS would not support the extended use of this type of medication. As such, the requested Clonazepam is not medically necessary or appropriate.

**30 Trazodone 100mg:** Upheld

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

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

**Decision rationale:** The Official Disability Guidelines support the use of this medication to address deficits in a patient's sleep hygiene, especially when there is a co-existing diagnosis of depression. The clinical documentation indicates that the patient has major depressive disorder and may benefit from this medication. However, continued use cannot be supported as ongoing evaluation of the patient's sleep hygiene was not provided within the medical documentation to support efficacy and determine the need for continued use. As such, the requested Trazodone is not medically necessary or appropriate

**60 Lamotrigine 25mg:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Scottish Intercollegiate Guidelines Network (SIGN). Bipolar affective disorder. A national clinic guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2005 May 41 p. (SIGN publication; no. 82)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation [www.rxlist.com/lamictal-drug/indications-dosage.htm](http://www.rxlist.com/lamictal-drug/indications-dosage.htm).

**Decision rationale:** RXlist, the internet drug index, indicated that the requested medication is used in the treatment of bipolar disorder and is considered a maintenance medication for stabilization of a mood disorder. This reference states that the physician who elects to prescribe Lamictal for periods extending beyond 16 weeks should periodically re-evaluate the drug's usefulness. The clinical documentation does not provide a quantitative objective assessment to determine the efficacy of this medication. Therefore, continued use would not be supported. The clinical documentation submitted for review does not provide any evidence that the patient has had a significant change in presentation as a result of the long term usage of this medication. As such, the requested Lamotrigine is not medically necessary or appropriate

**for 60 Lamotrigine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Scottish Intercollegiate Guidelines Network (SIGN). Bipolar affective disorder. A national clinic guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2005 May 41 p. (SIGN publication; no. 82)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation [www.rxlist.com/lamictal-drug/indications-dosage.htm](http://www.rxlist.com/lamictal-drug/indications-dosage.htm).

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**30 Topiramate 25mg:** Upheld

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

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

**Decision rationale:** The California MTUS states that a good response to the use of anti-epileptic drugs has been defined as a 50% reduction in pain and a moderate response as a 30% reduction in pain. The clinical documentation submitted for review does not provide any evidence of a pain response as it is related to this medication. Therefore, continued use would not be supported. As such, the requested Topiramate is not medically necessary or appropriate.

**30 Prilosec 20mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

**Decision rationale:** The California MTUS recommends the use of gastrointestinal protectants for patients who are at risk for developing gastrointestinal related events caused by medication usage. The clinical documentation submitted for review does not provide an evaluation of the

patient to determine the patient's risk for development of gastrointestinal events. Additionally, the most recent clinical documentation does not provide any assessment of the patient's gastrointestinal system that documents deficits that would require medication management. As such, the requested Prilosec is not medically necessary or appropriate.

**30 Zolpidem 10mg: Upheld**

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

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

**Decision rationale:** The Official Disability Guidelines state that Zolpidem is approved for the treatment of insomnia in the short term, usually 2-6 weeks. The clinical documentation submitted for review states that the patient has been on this medication for an extended duration of time. However, there are no specific assessments of the patient's sleep hygiene to support deficits that would require ongoing medication management. Therefore, the efficacy of this medication cannot be established. Additionally, as the patient has exceeded the 2-6 week treatment recommendation, continued use would not be supported. As such, the requested Zolpidem is not medically necessary or appropriate.