MAXIMUS Federal Services

Case Number:	CM13-0051077		
Date Assigned:	12/27/2013	Date of Injury:	04/06/2007
Decision Date:	03/10/2014	UR Denial Date:	10/21/2013
Priority:	Standard	Application Received:	11/14/2013

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 Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine 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 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 61-year-old male with date of injury on 04/06/2007. The progress report dated 09/03/2013 by [redacted] indicates the patient's diagnoses include: 1. Right knee internal derangement. 2. Postoperative deep vein thrombosis and pulmonary embolus, status post Greenfield filter placement and post phlebitis syndrome. 3. Symptoms of posttraumatic stress disorder. 4. Reactive depressive disorder. The patient continues with per back pain and pain radiating into his lower extremities. Objective findings include antalgic gait using a single point cane favoring his left lower extremity. There was generalized right knee tenderness with decreased range of motion. The utilization review letter dated 10/21/2013 issued noncertification of continued use of the following medications: 1. Wellbutrin XR 150 mg q. day. 2. Ambien 10 mg #30. 3. Topical creams.

IMR ISSUES, DECISIONS AND RATIONALES

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

Wellbutrin XR 150 mg QD #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13-15.

Decision rationale: The Physician Reviewer's decision rationale: The patient continues with persistent back pain and radiating pain into the right lower extremities. The patient has neuropathic pain as well as diagnosis of symptoms of posttraumatic stress disorder and reactive depressive disorder. Wellbutrin is a second-generation non-tricyclic antidepressant which has been shown to be effective in relieving neuropathic pain of different etiologies and a small trial according to MTUS page 13 through 15. This medication appears to be reasonable as the patient continues with symptoms of depression, posttraumatic stress disorder, and neuropathic pain. Therefore, authorization is recommended.

Ambien 10 mg QHS #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), 11th Edition web, 2013 Treatment Index, 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) ODG-TWC guidelines, Chronic Pain Chapter online, Zolpidem.

Decision rationale: The Physician Reviewer's decision rationale: The records appear to indicate that the patient has been prescribed Ambien as far back as 03/26/2013. The patient continues with persistent back pain and radiating symptoms into the lower extremities. The patient's symptoms of insomnia were not well documented on the most recent progress report; however, it is quite common for patients with chronic pain to experience symptoms of insomnia. MTUS is silent on the use of Ambien for insomnia; therefore, ODG Guidelines were reviewed which recommend Ambien as a treatment for short-term relief of insomnia, usually 2 to 6 weeks. The request for continued use of Ambien does not appear to be supported by the guidelines noted above for long-term use. Therefore, recommendation is for denial.

Topical creams: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The Physician Reviewer's decision rationale: The patient continues with chronic pain in the back as well as radiating symptoms into the lower extremities. The patient has an antalgic gait and favors his left lower extremity. There was generalized right knee tenderness with decreased range of motion on the most recent physical examination. MTUS page 111 through 113 regarding topical analgesics state that, "Any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended." The topical creams requested for this patient have not been identified in the records. It is unclear what ingredients are in topical creams. The utilization review letter dated 10/21/2013 does not specify

the ingredients in the topical creams. While certain topical compounds are allowed by MTUS, without identification of the ingredients of the topical cream, one cannot determine if there is medical necessity for the requested topical cream. Therefore, recommendation is for denial.