

<b>Case Number:</b>	CM14-0169820		
<b>Date Assigned:</b>	10/20/2014	<b>Date of Injury:</b>	10/26/2001
<b>Decision Date:</b>	11/20/2014	<b>UR Denial Date:</b>	09/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/14/2014

### 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 Preventive 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:

According to the records made available for review, this is a 44-year-old female with a 10/26/01 date of injury. At the time (9/10/14) of request for authorization for Topamax 100mg tablets, Wellbutrin XL 300mg tablets, Halcion .25 mg tablet, Rabeprazole sodium 20mg tablet, Piroxicam 20mg capsule, Trazodone HCL 50mg tablet, and Effexor XR 150mg, there is documentation of subjective (low back pain radiating to left leg ad calf) and objective (normal lower extremities motor strength and intact sensory examination) findings, current diagnoses (intervertebral lumbar disc disorder with myelopathy, failed back syndrome, depression, and gastritis), and treatment to date (medications (including ongoing treatment with (morphine sulfate, Topamax, Halcion, Trazodone, Effexor, Wellbutrin, Piroxicam, and Rabeprazole since at least 5/19/14)). Medical report identifies that the patient has difficulty going to sleep. Regarding Topamax, there is no documentation of failure of other anticonvulsants; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Topamax uses to date. Regarding Wellbutrin, Piroxicam, and Effexor, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Wellbutrin, Piroxicam, and Effexor use to date. Regarding Halcion, there is no documentation of short-term (up to 4 weeks) treatment; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Halcion use to date. Regarding Trazodone, there is no documentation of insomnia; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Trazodone use to date.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Topomax 100mg tablets:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Medication.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topiramate (Topamax) Page(s): 21. Decision based on Non-MTUS Citation Medical Evidence: Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain when other anticonvulsants have failed, as criteria necessary to support the medical necessity of Topiramate. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of intervertebral lumbar disc disorder with myelopathy, failed back syndrome, depression, and gastritis. In addition there is documentation of neuropathic pain. However, there is no documentation of failure of other anticonvulsants. In addition, given documentation of ongoing treatment with Topamax, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Topamax use to date. Therefore, based on guidelines and a review of the evidence, the request for Topamax 100mg tablets is not medically necessary.

### **Wellbutrin XL 300mg tablets:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain Page(s): 13-14. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress Chapter, Antidepressants, Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of chronic pain, as criteria necessary to support the medical necessity of antidepressants. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of depression, as criteria necessary to support the medical necessity of antidepressants. Within the medical information available for review, there is documentation of diagnoses of intervertebral lumbar disc disorder with myelopathy,

failed back syndrome, depression, and gastritis. In addition, there is documentation of depression and chronic pain. However, given documentation of ongoing treatment with Wellbutrin, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Wellbutrin use to date. Therefore, based on guidelines and a review of the evidence, the request for Wellbutrin XL 300mg tablets is not medically necessary.

**Halcion .25 mg tablet:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Medical Evidence: Title 8, California Code of Regulations, section 9792.20.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies that benzodiazepines are not recommended for long-term and that most guidelines limit use to 4 weeks. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of intervertebral lumbar disc disorder with myelopathy, failed back syndrome, depression, and gastritis. However, given documentation of records reflecting ongoing treatment with Halcion since at least 5/19/14, there is no documentation of short-term (up to 4 weeks) treatment; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Halcion use to date. Therefore, based on guidelines and a review of the evidence, the request for Halcion .25 mg tablet is not medically necessary.

**Rabeprazole sodium 20mg tablet:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms, and Cardiovascular Risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms, and Cardiovascular Risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Proton Pump Inhibitors (PPIs), Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies that risk for gastrointestinal event includes age > 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; and/or high dose/multiple NSAID. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase

in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of risk for gastrointestinal events and preventing gastric ulcers induced by NSAIDs, as criteria necessary to support the medical necessity of PPIs. Within the medical information available for review, there is documentation of diagnoses of intervertebral lumbar disc disorder with myelopathy, failed back syndrome, depression, and gastritis. In addition, given documentation of gastritis and ongoing treatment with NSAID, there is documentation of risk for gastrointestinal events. Therefore, based on guidelines and a review of the evidence, the request for Rabeprazole sodium 20mg tablet is medically necessary.

**Piroxicam 20mg capsule:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms, and Cardiovascular Risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non-Steroidal Anti-Inflammatory Drugs) Page(s): 67-68.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe osteoarthritis pain, acute low back pain, chronic low back pain, or exacerbations of chronic pain, as criteria necessary to support the medical necessity of NSAIDs. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of intervertebral lumbar disc disorder with myelopathy, failed back syndrome, depression, and gastritis. In addition, there is documentation of pain. However, given documentation of ongoing treatment with Piroxicam, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Piroxicam use to date. Therefore, based on guidelines and a review of the evidence, the request for Piroxicam 20mg capsule is not medically necessary.

**Trazodone HCL 50mg tablet:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines SSRIs (Selective Serotonin Reuptake Inhibitors Page(s): 107. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress, Trazodone (Desyrel), Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines identifies that selective serotonin reuptake inhibitors (SSRIs) are not recommended as a treatment for chronic pain, but may have a role in treating secondary depression. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or

improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of insomnia with potentially coexisting mild psychiatric symptoms (such as depression or anxiety), as criteria necessary to support the medical necessity of Trazodone (Desyrel). Within the medical information available for review, there is documentation of diagnoses of intervertebral lumbar disc disorder with myelopathy, failed back syndrome, depression, and gastritis. In addition, there is documentation of neuropathic pain and ongoing treatment with Trazodone. However, despite documentation of a diagnosis of depression and the patient has difficulty going to sleep, there is no documentation of insomnia. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Trazodone use to date. Therefore, based on guidelines and a review of the evidence, the request for Trazodone HCL 50mg tablet is not medically necessary.

**Effexor XR 150mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain Page(s): 13-14. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress Chapter, Antidepressants, Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of chronic pain, as criteria necessary to support the medical necessity of antidepressants. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of depression, as criteria necessary to support the medical necessity of antidepressants. Within the medical information available for review, there is documentation of diagnoses of intervertebral lumbar disc disorder with myelopathy, failed back syndrome, depression, and gastritis. In addition, there is documentation of depression and chronic pain. However, given documentation of ongoing treatment with Effexor, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Effexor use to date. Therefore, based on guidelines and a review of the evidence, the request for Effexor XR 150mg is not medically necessary.