

<b>Case Number:</b>	CM14-0027390		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	07/12/2013
<b>Decision Date:</b>	11/03/2014	<b>UR Denial Date:</b>	01/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/04/2014

### 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, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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:

This patient is a 34 year old employee with date of injury of 7/12/2013. Medical records indicate the patient is undergoing treatment for cervical syndrome with radiculopathy; right and left shoulder pain and right and left wrist sprain/carpal tunnel syndrome. She has also been diagnosed with major depressive disorder, panic disorder without agoraphobia and other psychological factors affecting medical condition. Subjective complaints include constant pain in the cervical spine that is localized to the midline posteriorly. The pain varies between "dull, aching" to a "sharp" sensation. Sometimes it is a burning pain. Pain radiates from her neck down both upper limbs, aching. She has numbness, weakness and tingling in her upper extremities. She has headaches. She also has pain from the neck to the back of the head and at times she has been vomiting with visual disturbances. Pain in the cervical region is aggravated by movement. Using the upper extremities above the shoulder level causes pain as well as prolonged positioning of the neck. Pain is aggravated by cold, damp weather and pushing, pulling and lifting. Rest, heating pads and taking medications alleviate symptoms. She complains of constant pain to her bilateral shoulders and her right and left wrists/hands. She has weakness, numbness, swelling and tingling in both the shoulders and wrists/hands. She occasionally feels a popping or clicking in the shoulders. Pain is aggravated by lifting, pushing, pulling, gripping and writing. As a result of being unable to do ADL's to the fullest extent, she rates her anxiety as 9/10. Anxiety or apprehension due to pain is a 10. Objective findings include tenderness to palpation in the posterior aspect of the cervical spine and right and left trapezius muscles. There is tenderness along the vertebral borders of the scapulae. There was subacromial tenderness to palpation over the right shoulder and generalized tenderness to palpation over the left shoulder. Impingement test I was equivocal on the right, Impingement II was equivocal on the left. The patient complained of pain at the extreme with forward flexion, extension, adduction, abduction and

internal and external rotation of the right and left shoulders. There was palmar, dorsal and radial sided tenderness to palpation over the right and left wrists and slight ulnar tenderness over the right wrist. Tinel's, Phalens was positive on both right and left. There was pain and tingling in both the left and right thumb and index finger. There was pain at the extreme with dorsiflexion, palmar flexion and radial deviation of the right and left wrists. A Comprehensive P&S report found the patient to have a marked degree of mental and behavioral impairment according to AMA guidelines with a GAF of 50. Treatment has consisted of bilateral wrist braces, Omeprazole, Naproxen, Gabapentin, Tylenol #3, Ketapine, Bupropion and Lorazepam. She has used a heating pad for pain. The utilization review determination was rendered on 1/30/2014 recommending non-certification of Lorazepam quantity one; Bupropion quantity one and Quetiapine Fumarate quantity one.

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

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

#### **LORAZEPAMQUANTITY ONE: Overturned**

**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 Benzodiazepines, Page(s): 24.

**Decision rationale:** MTUS states that benzodiazepine (ie Lorazepam) is "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. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks." Medical documentation provided state that the patient is diagnosed with adjustment with mixed emotional features, anxiety, and depression. On July 19, 2014 documentation from [REDACTED], clinical professor of Psychiatry states " psychiatric treatment is reasonable for this woman in the form of provision for medication management, seeing a psychiatrist no more than once a month for one year". Lorazepam is an anxiolytic that would aid in the short term treatment of anxiety. As such, the request for Lorazepam quantity one is medically necessary.

#### **BUPROPIANQUANTITY ONE: Overturned**

**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 Bupropion (Wellbutrin) Page(s): 16,125. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress, Bupropion (Wellbutrin)

**Decision rationale:** MTUS states that "Bupropion (Wellbutrin), a second-generation non-tricyclic antidepressant (a noradrenaline and dopamine reuptake inhibitor) has been shown to be effective in relieving neuropathic pain of different etiologies in a small trial (41 patients). While bupropion has shown some efficacy in neuropathic pain there is no evidence of efficacy in patients with non- neuropathic chronic low back pain. (Katz, 2005) Furthermore, a recent review suggested that bupropion is generally a third-line medication for diabetic neuropathy and may be considered when patients have not had a response to a tricyclic or SNRI. Side-effect profile: Headache, agitation, insomnia, anorexia, weight loss Dosing Information: Neuropathic pain (off-label indication): 100 mg once daily, increase by 100 mg per week up to 200 mg twice daily)". ODG states "Recommended as a first-line treatment option for major depressive disorder. See Antidepressants for treatment of MDD (major depressive disorder). FDA has concluded that the generic drug Budeprion XL (bupropion hydrochloride) cannot be considered therapeutically equivalent to the brand-name product Wellbutrin. . Medical documentation provided state that the patient is diagnosed with adjustment with mixed emotional features, anxiety, and depression. On July 19, 2014 documentation from [REDACTED], clinical professor of Psychiatry states " psychiatric treatment is reasonable for this woman in the form of provision for medication management, seeing a psychiatrist no more than once a month for one year". Bupropion is a first line agent in the treatment of depression. As such, the request for Bupropion is medically necessary.

**QUETIAPINE FUMARATE QUANTITY ONE:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress, Seroquel (quetiapine)

**Decision rationale:** ODG states "Not recommended as a first-line treatment. There is insufficient evidence to recommend atypical antipsychotics (e.g., quetiapine, Risperidone) for conditions covered in ODG. See Atypical antipsychotics; & PTSD pharmacotherapy. See also Anxiety medications in chronic pain in the Chronic Pain Chapter". Additionally, ODG states "Not recommended as a first-line treatment. There is insufficient evidence to recommend atypical antipsychotics (e.g., quetiapine, Risperidone) for conditions covered in ODG. See PTSD pharmacotherapy. Adding an atypical antipsychotic to an antidepressant provides limited improvement in depressive symptoms in adults, new research suggests. The meta-analysis also shows that the benefits of antipsychotics in terms of quality of life and improved functioning are small to nonexistent, and there is abundant evidence of potential treatment-related harm. The authors said that it is not certain that these drugs have a favorable benefit-to-risk profile. Clinicians should be very careful in using these medications". On July 19, 2014 documentation from [REDACTED], clinical professor of Psychiatry states " psychiatric treatment is reasonable for this woman in the form of provision for medication management, seeing a psychiatrist no more than once a month for one year". The treating physician did not document a diagnosis of PTSD and the treating physician did not detail why an antipsychotic was needed at this time. Guidelines

advise caution when adding an antipsychotic to an antidepressant. As such, the request for Quetiapine Fumarate quantity one is not medically necessary at this time