

<b>Case Number:</b>	CM14-0189435		
<b>Date Assigned:</b>	11/21/2014	<b>Date of Injury:</b>	08/28/1998
<b>Decision Date:</b>	01/08/2015	<b>UR Denial Date:</b>	10/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/13/2014

### 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 Occupational 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:

Patient is a 54 year-old male with date of injury 08/28/1998. The medical document associated with the request for authorization, a therapeutic pain management progress report, dated 10/23/2014, lists subjective complaints as pain in the neck and low back. Objective findings: Examination of the lumbar spine revealed tenderness to palpation of the facet joints and bilateral paraspinals. Facet loading test was positive bilaterally. Range of motion was restricted and painful. Straight leg raising test was negative. No examination of the cervical spine was documented. Diagnosis: Postlaminectomy syndrome, lumbar 2. Postlaminectomy syndrome, cervical 3. Chronic pain syndrome 4. Degeneration of lumbar or lumbosacral intervertebral disc 5. Lumbosacral spondylosis without myelopathy 6. Cervical spondylosis 7. Testicular hypofunction 8. Major depressive disorder 9. Gastritis 10. Anxiety 11. Nausea 12. Constipation 13. Abdominal tenderness 14. Displacement of cervical intervertebral disc without myelopathy 15. Chronic depressive personality disorder. The medical records supplied for review document that the patient has been taking the following medications for at least as far back as three months. Medication: 1. Buspar 13mg, #30 SIG: 2 tablets TID 2. Naprosyn 500mg, #60 SIG: one tablet as needed once a day 3. Fortesta gel 10mg, #1 SIG: BID 4. Sertraline 30mg, #30 SIG: one tablet QD 5. Methadone 10mg, #120 SIG: 1 cap QID.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Buspar 13mg #30 (30 day supply), refills:00: Overturned**

**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) Pain (Chronic), Anxiety medications in chronic pain

**Decision rationale:** The Official Disability Guidelines recommend diagnosing and controlling anxiety as an important part of chronic pain treatment, including treatment with anxiety medications based on specific DSM-IV diagnosis. Buspirone, trade name Buspar, is an anxiolytic psychotropic drug of the azapirone chemical class. Buspirone is approved in the United States by the FDA for the treatment of anxiety disorders and the short-term relief of the symptoms of anxiety. The patient has been diagnosed with anxiety disorder. I am reversing the previous utilization review decision. Buspar 13mg #30 (30 day supply) is medically necessary.

**Naprosyn 500mg #60 (30 day supply), refills: 00: 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 9792.20 - 9792.26 Page(s): 67-73.

**Decision rationale:** The MTUS recommends NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence of long-term effectiveness for pain or function. Naprosyn 500mg #60 (30 day supply) is not medically necessary.

**Fortesta gel 10mg #1 (30 day supply), refills: 00: 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) Pain (Chronic), Testosterone replacement for hypogonadism (related to opioids)

**Decision rationale:** The Official Disability Guidelines recommend testosterone replacement for hypogonadism related to high-dose opioids. Hypogonadism has been noted in patients receiving intrathecal opioids and long-term high dose opioids. Routine testing of testosterone levels in men taking opioids is not recommended. If needed, testosterone replacement should be done by a physician with special knowledge in this field given the potential side effects such as hepatomas. There is no documentation of hypogonadism, nor is there documentation that the testosterone replacement therapy is being provided by a physician with special knowledge in the field. Fortesta gel 10mg #1 (30 day supply) is not medically necessary.

**Sertraline 30mg #30 (30 day supply), refills: 00:** 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 9792.20 - 9792.26 Page(s): 13.

**Decision rationale:** Sertraline (trade names Zoloft, Lustral) is an antidepressant of the selective serotonin reuptake inhibitor (SSRI) class. The MTUS recommends antidepressants as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain, but tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. There is no documentation in the medical record that tricyclics have been ineffective, poorly tolerated, or contraindicated. Sertraline 30mg #30 (30 day supply) is not medically necessary.

**Methadone 10mg #120 (30 day supply), refill: 00:** 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) Pain (Chronic), Methadone

**Decision rationale:** Routine long-term opioid therapy is not recommended, and The Official Disability Guidelines recommends consideration of a one-month limit on opioids for new chronic non-malignant pain patients in most cases, as there is little research to support use. The research available does not support overall general effectiveness and indicates numerous adverse effects with long-term use. The latter includes the risk of ongoing psychological dependence with difficulty weaning. The ODG recommends methadone as a second-line drug for moderate to severe pain, only if the potential benefit outweighs the risk, unless methadone is prescribed by pain specialists with experience in its use and by addiction specialists, where first-line use may be appropriate. There is no documentation that first-line drug therapy has failed. Methadone 10mg #120 (30 day supply) is not medically necessary.