

Case Number:	CM14-0189521		
Date Assigned:	11/20/2014	Date of Injury:	09/28/2003
Decision Date:	01/08/2015	UR Denial Date:	10/13/2014
Priority:	Standard	Application Received:	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 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 50-year-old female with a 9/28/03 date of injury. At the time (10/15/14) of request for authorization for Klonopin 1mg, Restoril 30mg, Wellbutrin 200mg, Cymbalta 30mg, Tramadol/APAP 37.5/325mg, Topiramate 50mg, and Gabapentin 600mg, there is documentation of subjective (neck, upper back, and lower back pain) and objective (decreased cervical and lumbar range of motion; multiple myofascial trigger points and tau bands noted throughout the cervical paraspinal, trapezius, levator scapulae, scalene, thoracic paraspinals, and lumbar paraspinals; decreased sensation to pinprick in the lateral aspect of the left arm, first 3 digits of the left hand, and posterior and lateral aspects of the left thigh; and decreased strength of the upper proximal muscles, upper distal muscles, and dorsiflexion and plantar flexion of the left foot) findings, current diagnoses (major depression and insomnia and chronic myofascial pain syndrome of the cervical and thoracolumbar spine), and treatment to date (medications (including ongoing treatment with Klonopin, Restoril, Wellbutrin, Cymbalta, Tramadol, Topiramate, and Gabapentin). Medical report identifies that medications improved the patient's activities of daily living and provided pain relief; and that there is ongoing opioid treatment assessment. Regarding Klonopin and Restoril, 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 specific result of Klonopin and Restoril use to date. Regarding Wellbutrin, Cymbalta, and Gabapentin, 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 specific result of Wellbutrin, Cymbalta, and Gabapentin use to date. Regarding Tramadol/APAP, there is no documentation of short-term (5 days) treatment; and 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 specific result of Tramadol/APAP use to date. Regarding Topiramate, there is no documentation of failure of other anticonvulsants; and 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 specific result of Topiramate use to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Klonopin 1mg: 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 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 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 major depression and insomnia and chronic myofascial pain syndrome of the cervical and thoracolumbar spine. However, given documentation of ongoing treatment with Klonopin, there is no documentation of short-term (up to 4 weeks) treatment. In addition, despite documentation that medications improved the patient's activities of daily living and provided pain relief, 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 specific result of Klonopin use to date. Therefore, based on guidelines and a review of the evidence, the request for Klonopin 1mg is not medically necessary.

Restoril 30mg: 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 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 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 major depression and insomnia and chronic myofascial pain syndrome of the cervical and thoracolumbar spine. However, given documentation of ongoing treatment with Restoril, there is no documentation of short-term (up to 4 weeks) treatment. In addition, despite documentation that medications improved the patient's activities of daily living and provided pain relief, 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 specific result of Restoril use to date. Therefore, based on guidelines and a review of the evidence, the request for Restoril 30mg is not medically necessary.

Wellbutrin 200mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental Illness and Stress

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 major depression and insomnia and chronic myofascial pain syndrome of the cervical and thoracolumbar spine. In addition, there is documentation of depression and chronic pain. However, despite documentation that medications improved the patient's activities of daily living and provided pain relief, 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 specific result of Wellbutrin use to date. Therefore, based on guidelines and a review of the evidence, the request for Wellbutrin 200mg is not medically necessary.

Cymbalta 30mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duloxetine (Cymbalta) Page(s): 43-44. Decision based on Non-MTUS Citation Official

Disability Guidelines (ODG) Chronic Pain Chapter, Antidepressants for chronic pain 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 major depression and insomnia and chronic myofascial pain syndrome of the cervical and thoracolumbar spine. In addition, there is documentation of depression and chronic pain. However, despite documentation that medications improved the patient's activities of daily living and provided pain relief, 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 specific result of Cymbalta use to date. Therefore, based on guidelines and a review of the evidence, the request for Cymbalta 30mg is not medically necessary.

Tramadol/APAP 37.5/325mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Opioids, specific drug list Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. 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 states Tramadol/APAP is indicated for short term use (5 days) in acute pain management. Within the medical information available for review, there is documentation of diagnoses of major depression and insomnia and chronic myofascial pain syndrome of the cervical and thoracolumbar spine. In addition, given documentation that there is ongoing opioid treatment assessment, there is documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. However, given documentation of ongoing treatment with Tramadol/APAP, there is no documentation of short-term (5 days) treatment. In addition,

despite documentation that medications improved the patient's activities of daily living and provided pain relief, 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 specific result of Tramadol/APAP use to date. Therefore, based on guidelines and a review of the evidence, the request for Tramadol/APAP 37.5/325mg is not medically necessary.

Topiramate 50mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topiramate (Topamax) Page(s): 21. Decision based on Non-MTUS Citation 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 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 major depression and insomnia and chronic myofascial pain syndrome of the cervical and thoracolumbar spine. In addition, there is documentation of neuropathic pain. However, given documentation of associated request for Gabapentin, there is no documentation of failure of other anticonvulsants. In addition, despite documentation that medications improved the patient's activities of daily living and provided pain relief, 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 specific result of Topiramate use to date. Therefore, based on guidelines and a review of the evidence, the request for Topiramate 50mg is not medically necessary.

Gabapentin 600mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 18-19. Decision based on Non-MTUS Citation 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 neuropathic pain, as criteria necessary to support the medical necessity of Neurontin (Gabapentin). 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 major depression and insomnia and chronic myofascial pain syndrome of the cervical and thoracolumbar spine. In addition, there is documentation of neuropathic pain. However, despite documentation that medications improved the patient's activities of daily living and provided pain relief, 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 specific result of Gabapentin use to date. Therefore, based on guidelines and a review of the evidence, the request for Gabapentin 600m is not medically necessary.