

Case Number:	CM15-0017561		
Date Assigned:	02/05/2015	Date of Injury:	12/11/2008
Decision Date:	04/02/2015	UR Denial Date:	01/20/2015
Priority:	Standard	Application Received:	01/29/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 injured worker is a 51 year old female, who sustained an industrial injury on 12/11/2008 when she slipped in water from a refrigerator leak and fell onto her back. The diagnoses have included chronic low back pain, sciatica, radiculitis and depressive disorder related to chronic pain. Treatment to date has included diagnostics, medications, physical therapy and epidural steroid injections. Currently, the IW complains of back stiffness, numbness in the legs, and radicular pain with weakness in the legs. She is noted to have substantial benefit from medications. Objective findings included lumbar tenderness and a positive stork test bilaterally. There is decreased light touch sensation to the S1 dermatome and L4 dermatome on the right. On 1/20/2015, Utilization Review non-certified a request for Inderal 20mg #30 and Soma 350mg #90 and modified a request for Opana ER 15mg #60, Percocet 10/325mg #280 and Wellbutrin SR 15mg #60, noting that the clinical findings do not support the medical necessity of the treatment, particularly for long term use. The MTUS and ODG were cited. On 1/29/2015, the injured worker submitted an application for IMR for review of Percocet 10/325mg #280, Wellbutrin SR 15mg #60, Inderal 20mg #30, Opana ER 15mg #60 and Soma 350mg #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg QTY: 280.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for Chronic Pain Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: The patient presents with back stiffness, numbness in the legs, and radicular pain rated 7-8/10 with weakness in the legs. The request is for PERCOCET 10/325MG QTY: 280.00. The RFA is not provided. Patient's diagnosis included chronic low back pain, sciatica, radiculitis and depressive disorder related to chronic pain. Patient is permanent and stationary. For chronic opiate use in general, MTUS Guidelines page 88 and 89 states, "patient should be assessed at each visit and functioning should be measured at 6-month intervals using the numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior) as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. Per the progress report dated 12/05/14, treater states, "the patient has been continuing note substantial benefit of the medications and is working without restrictions, and she has nociceptive, neuropathic and inflammatory pain. There is no evidence of drug abuse or diversion, no aberrant behavior observed and no ADRs reported. Medication was reviewed and DDI was checked, she has no side effects, no complications, no aberrant behavior, UDS is WNL as they all are, she has no signs of illicit drug abuse, diversion, habituation and is on the lowest effective dosing, with about 60% improvement in pain." The urine toxicology administered on 12/05/14 was consistent with the prescribed medications. Although, the treater provides and discusses the patient's side effects/aberrant behavior, there are no before and after pain scales provided to assess analgesia nor there are any specific examples of ADLs which would demonstrate medication efficacy. There is no opiate management issues discussed such as CURES report, pain contracts, et cetera. No outcome measures are provided either as required by MTUS Guidelines. In this case, the treating physician does not provide proper documentation that is required by MTUS Guidelines for continued opiate use. Therefore, the request IS NOT medically necessary.

Wellbutrin SR 150mg QTY: 60.00 with 3 Refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Depressants for Chronic Pain Page(s): 13-16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SPECIFIC ANTIDEPRESSANTS, Bupropion (Wellbutrin) Page(s): 16, 13-15.

Decision rationale: The patient presents with back stiffness, numbness in the legs, and radicular pain rated 7-8/10 with weakness in the legs. The request is for WELLBUTRIN SR 150MG QTY 60 3 REFILLS. The RFA is not provided. Patient's diagnosis included chronic low back pain, sciatica, radiculitis and depressive disorder related to chronic pain. Patient is permanent and stationary. MTUS guidelines under: SPECIFIC ANTIDEPRESSANTS, page 16, for Bupropion (Wellbutrin) states this is a second-generation non-tricyclic antidepressant (a noradrenaline and

dopamine reuptake inhibitor) has been shown to be effective in relieving neuropathic pain. MTUS Guidelines regarding antidepressants page 13 to 15 states, "While bupropion has shown some efficacy in neuropathic pain, there is no evidence of efficacy on patient with non-neuropathic chronic low back pain." The patient has been utilizing Wellbutrin SR since 07/01/14 for depression due to her chronic pain. The review of the reports indicates that the patient suffers from chronic low back pain and numbness in the legs as well as radicular pain. The patient also has been diagnosed with depressive disorder related to chronic pain. This patient meets the indication for this medication as there is report of neuropathic pain and depression. The request of Wellbutrin SR IS medically necessary.

Inderal 20mg QTY: 30.00 with 3 Refills: 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), Diabetes.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Head Chapter: Botulinum toxin for chronic migraine.

Decision rationale: The patient presents with back stiffness, numbness in the legs, and radicular pain rated 7-8/10 with weakness in the legs. The request is for INDERAL 20MG QTY 30 3 REFILLS. The RFA is not provided. Patient's diagnosis included chronic low back pain, sciatica, radiculitis and depressive disorder related to chronic pain. Patient is permanent and stationary. MTUS is silent regarding this drug. ODG-TWC: Head Chapter: Botulinum toxin for chronic migraine states: "Criteria for botulinum toxin (Botox) for prevention of chronic migraine headaches: - Amitriptyline, beta blockers (metoprolol, propranolol, and timolol), topiramate as well as valproic acid and its derivatives, are first-line agents for the treatment of chronic migraines." ODG guidelines mentions propranolol in the context of migraine treatments trial prior to trying botox. This medication was first mentioned in the 07/01/14 report; it is unknown exactly when the patient initially started taking this medication. In this case, there is no diagnosis of migraine nor there is complaint of headaches. There is no indication that the patient is experiencing migraine headaches. ODG supports Propranolol for chronic migraines, but the treating physician has failed to document that the patient has chronic migraines. The request IS NOT medically necessary.

Opana ER 15mg QTY: 60.00: 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 CRITERIA FOR USE OF OPIOIDS, Hydrocodone Page(s): 76-78, 88-89, 90.

Decision rationale: The patient presents with back stiffness, numbness in the legs, and radicular pain rated 7-8/10 with weakness in the legs. The request is for OPANA ER 15MG QTY 60. The RFA is not provided. Patient's diagnosis included chronic low back pain, sciatica, radiculitis and

depressive disorder related to chronic pain. Patient is permanent and stationary. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. MTUS p90 states, "Hydrocodone has a recommended maximum dose of 60mg/24hrs." In this case, a prescription for Opana ER is first noted in progress report dated 07/01/14. Per the progress report dated 12/05/14, treater states, "the patient has been continuing to note substantial benefit of the medications and is working without restrictions, and she has nociceptive, neuropathic and inflammatory pain. There is no evidence of drug abuse or diversion, no aberrant behavior observed and no ADRs reported. Medication was reviewed and DDI was checked, she has no side effects, no complications, no aberrant behavior, UDS is WNL as they all are, she has no signs of illicit drug abuse, diversion, habituation and is on the lowest effective dosing, with about 60% improvement in pain." The urine toxicology administered on 12/05/14 was consistent with the prescribed medications. Although, the treater provides and discusses the patient's side effects/aberrant behavior, there are no before and after pain scales provided to assess analgesia nor there are any specific examples of ADLs which would demonstrate medication efficacy. There is no opiate management issues discussed such as CURES report, pain contracts, et cetera. No outcome measures are provided either as required by MTUS Guidelines. In this case, the treating physician does not provide proper documentation that is required by MTUS Guidelines for continued opiate use. Therefore, the request IS NOT medically necessary.

Soma 305 mg QTY: 90.00 with 3 Refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants for Pain, Carisoprodol (Soma) Page(s): 64-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

Decision rationale: The patient presents with back stiffness, numbness in the legs, and radicular pain rated 7-8/10 with weakness in the legs. The request is for SOMA 305 MG QTY 90 3 REFILLS. The RFA is not provided. Patient's diagnosis included chronic low back pain, sciatica, radiculitis and depressive disorder related to chronic pain. Patient is permanent and stationary. MTUS Guidelines, pages 63-66, "Carisoprodol (Soma): Neither of these formulations is recommended for longer than a 2- to 3-week period." This has been noted for sedated and relaxant effects. MTUS recommends the requested Soma for no more than 2 to 3 weeks. This prescription was first noted in the progress report dated 07/01/14. In this case, the treater has requested for 90 tablets of Soma with 3 refills. The request does not indicate intended short-term use of this medication. Therefore, the request IS NOT medically necessary.