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| Case Number: | CM15-0027100 | | |
| Date Assigned: | 02/19/2015 | Date of Injury: | 09/10/2002 |
| Decision Date: | 04/17/2015 | UR Denial Date: | 01/15/2015 |
| Priority: | Standard | Application Received: | 02/12/2015 |

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: North Carolina

Certification(s)/Specialty: Family Practice

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 46 year old male who sustained a work related injury September 10, 2002. While on a forklift was hit from behind by another forklift and was jostled in place and initially felt a burning in the lower back. After a few hours, pain was present in the neck, mid-back, and both buttocks and a week later headaches. Past history included lumbar fusion with insertion of hardware and a left iliac crest bone graft January 2004, spinal cord stimulator 2011. According to a primary treating physician's progress report date January 6, 2015, the injured worker presented with pain level 6/10 with medication and 8/10 without medication. He is concerned that medications have not been authorized and the spinal cord stimulator does not provide the medication due to scar tissue formation in the epidural space. Diagnosis is documented as chronic pain disorder. Treatment includes request for medication; Wellbutrin, Methadone and Butrans. According to utilization review dated January 15, 2015, the request for Wellbutrin 150 XL #90 has been modified to Wellbutrin 150 XL #30, citing MTUS Chronic Pain Medical Treatment Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Wellbutrin 150 XL #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Wellbutrin (bupropion). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Bupropion (Wellbutrin).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines wellbutrin Page(s): 16.

Decision rationale: The California MTUS section on Wellbutrin states: 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). (Finnerup, 2005) While bupropion has shown some efficacy in neuropathic pain there is no evidence of efficacy in patients with nonneuropathic 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. (Dworkin, 2007) The patient has neuropathic pain and has a positive response to the medication. Therefore the request is certified.