

Case Number:	CM15-0033372		
Date Assigned:	02/26/2015	Date of Injury:	10/08/2012
Decision Date:	04/08/2015	UR Denial Date:	02/09/2015
Priority:	Standard	Application Received:	02/23/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

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 62 year old male sustained a work related injury on 10/08/2012. According to a progress report dated 01/28/2015, the injured worker had been on Keppra 2000mg for one month with restless leg getting worse. He complained of neck and lower back pain, disequilibrium, anxiety, paranoia, impatience, progressive memory and cognitive difficulties, and insomnia with hyperphagia rule out parasomnia. Objective findings included bradykinesia, orientation to person only, ataxia, myoclonic jerking and tremor, left lower extremity radiculopathy with positive Romberg, bilateral upper extremity tremor and abnormal EEG (electroencephalogram) with T6 epileptiform focus but qualified such due to artifact. MRI of the brain on 04/21/2014 was within normal limits. On 10/12/2014 the injured worker was qualified with severe obstructive sleep apnea. Diagnoses included nocturnal myoclonus, traumatic encephalopathy and severe obstructive sleep apnea. Treatment plan included continue Mirapex, repeat EEG sleep deprived on Keppra, Levetiracetam, orthopedic evaluation for knees and lower back, refill Alprazolam, Citalopram, Norco, Klonopin and Omeprazole, MRI of the brain and neuropsychyhe testing. On 02/09/2015, Utilization Review non-certified Levetiracetam 500mg #60, Alprazolam 0.15mg #30 and Citalopram 20mg #15. According to the Utilization Review physician, the injured worker has been on Keppra 2000mg for a month with worsening symptoms. Levetiracetam is in the same drug class as Keppra. The provider did not give a rationale as to why the same type of medication was being prescribed when the patient was unresponsive previously. CA MTUS Chronic Pain Medical Treatment Guidelines was referenced. In regard to

Alprazolam, guidelines limit the use of benzodiazepines to 4 weeks. There was no information on treatment history and efficacy of the prior use of this medication. Additionally the provider's request would exceed guidelines. CA MTUS Chronic Pain Medical Treatment Guidelines, page 24 was referenced. In regard to Citalopram, the injured worker had no signs or symptoms or diagnosis of secondary depression. There was no information on treatment history and length of time the injured worker has been prescribed this medication. The efficacy of the prior use of the medication was not provided to support continued use. CA MTUS Chronic Pain Medical Treatment Guidelines, page 107 was referenced. The decision was appealed for an Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Levetiracetam 500mg #120: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Head, Anticonvulsants and Other Medical Treatment Guidelines Epocrates, <https://online.epocrates.com>, Levetiracetam (Keppra).

Decision rationale: ODG states "Recommended. For adult patients with severe TBI, prophylaxis with phenytoin is effective in decreasing the risk of early post-traumatic seizures and can be administered for 1 or 2 weeks without a significant increase in drug-related side effects. AED prophylaxis is not shown to be effective in decreasing the risk of late post-traumatic seizures, nor is it associated with a reduction in mortality rate or neurological disability. (Chang, 2003) (Colorado, 2005) (Haltiner, 1999) (Haltiner, 1996) (Schierhout, 1998) (Smith, 1996) (Temkin, 2001) (Temkin, 1999) (Young, 1983)." Epocrates notes that Levetiracetam (Keppra) is prescribed for partial seizures, adjunct tx juvenile myoclonic epilepsy, adjunct tx primary generalized tonic clonic seizures, adjunct tx. The treating physician notes the patient Levetiracetam (Keppra) for over a month with worsening symptoms. The treating physician does not detail why treatment with Levetiracetam (Keppra) should continue in lieu of the patient not having functional improvement. The previous reviewer recommended weaning. As such the request for Levetiracetam 500mg #120 is not medically necessary.

Alprazolam 0.15mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain and Mental Illness, Benzodiazepines.

Decision rationale: MTUS and ODG states that benzodiazepine (ie Alprazolam) 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. ODG further states regarding Alprazolam not recommended. Medical records indicate that the patient has been on Alprazolam 0.15mg #60 for months, far exceeding MTUS recommendation of 4 week short term treatment. The medical record does not provide any extenuating circumstances to recommend exceeding the guideline recommendations. The previous reviewer recommended weaning. As such, the request for Alprazolam 0.15mg #60 is not medical necessary.

Citalopram 20mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 15-16. Decision based on Non-MTUS Citation Epocrates, Celexa monograph
<https://online.epocrates.com/noFrame/showPage.do?method=drugs&MonographId=496>.

Decision rationale: Celexa (citalopram) is a selective serotonin reuptake inhibitor (SSRI) and is FDA approved for the treatment of depression. Its role in chronic pain is less clear. MTUS states "Selective serotonin and norepinephrine reuptake inhibitors (SNRIs): Duloxetine (Cymbalta): FDA-approved for anxiety, depression, diabetic neuropathy, and fibromyalgia. Used off-label for neuropathic pain and radiculopathy. Duloxetine is recommended as a first-line option for diabetic neuropathy. (Dworkin, 2007) No high quality evidence is reported to support the use of duloxetine for lumbar radiculopathy. (Dworkin, 2007) More studies are needed to determine the efficacy of duloxetine for other types of neuropathic pain. Side effects: CNS: dizziness, fatigue, somnolence, drowsiness, anxiety (3% vs.2% for placebo), insomnia (8-13% vs. 6-7% for placebo). GI: nausea and vomiting (5-30%), weight loss (2%). Trial period: Some relief may occur in first two weeks; full benefit may not occur until six weeks. Withdrawal effects can be severe. Abrupt discontinuation should be avoided and tapering is recommended before discontinuation." MTUS additionally states concerning SSRIs and pain "Selective serotonin reuptake inhibitors (SSRIs), a class of antidepressants that inhibit serotonin reuptake without action on noradrenaline, are controversial based on controlled trials. (Finnerup, 2005) (Saarto-Cochrane, 2005). It has been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain. (Namaka, 2004) More information is needed regarding the role of SSRIs and pain." The treating physician has not provided the reason for prescribing the Celexa and documentation of a decrease in symptoms. Additionally, there are no treatment notes that discuss the length of time that the patient has been taking this medication. As such, Citalopram 20mg #30 is not medically necessary.