

<b>Case Number:</b>	CM14-0132601		
<b>Date Assigned:</b>	08/20/2014	<b>Date of Injury:</b>	07/02/2001
<b>Decision Date:</b>	09/30/2014	<b>UR Denial Date:</b>	07/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/15/2014

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Pain 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:

The injured worker is a 54-year-old male who reported an injury on 07/02/2001 due to an unknown mechanism. Diagnoses were chronic pain syndrome; low back pain, chronic; degenerative disc disease; neck pain, chronic; migraine headache; depression/anxiety; tremor; and history of arthrodesis anterior. Past treatments were medications, walking, and daily stretching regimen. Diagnostic studies and surgical history were not reported. The physical examination on 08/13/2014 revealed complaints of chronic pain and back pain. The injured worker reported the average pain was a 1/10 and the worst pain was a 2/10. The injured worker reported the pain was worse in the morning. The examination revealed axial lower back pain was increased with trunk extension to the right and the left. Points of maximum tenderness were over the right and left lower lumbar facets. The treatment plan was to continue medications as directed. The rationale and Request for Authorization were not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Glucosamine Chondroitin 1500 #60 with 2 refills:** 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, Glucosamine.

**Decision rationale:** The request for glucosamine Chondroitin 1500 quantity of 60 with 2 refills is not medically necessary. The Official Disability Guidelines (ODG), states for glucosamine that it is recommended as an option (glucosamine sulfate only) given its low risk in injured workers with moderate arthritis pain, especially for knee or osteoarthritis. Studies have demonstrated a highly significant efficacy for the crystalline glucosamine sulfate on all outcomes, including joint space narrowing, pain, mobility, safety, and response to treatment, but similar studies are lacking for Glucosamine Hydrochloride. For all herbals and dietary supplements, there may be concerns for potential interactions with prescription and over-the-counter medications and lack of manufacturing quality controls. Compelling evidence exists that Glucosamine may reduce the progression of knee osteoarthritis. Results obtained with Glucosamine may not be extrapolated to other salts or formulations in which no warranty exists about content. The efficacy of this medication was not reported. Also, the request does not indicate a frequency for the medication. Therefore, it is not medically necessary.

**Wellbutrin 75mg #90 with 2 refills:** 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 Antidepressants, Bupropion Page(s): 13, 16.

**Decision rationale:** The request for Wellbutrin 75 mg quantity 90 with 2 refills is not medically necessary. The California Medical Treatment Utilization Schedule states that antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesics medicine, sleep quality and duration, and a psychological assessment. Long-term effectiveness of antidepressants has not been established. The effect of this class of medication in combination with other classes of drugs has not been well-researched. Wellbutrin is a second generation non-tricyclic antidepressant and has been shown to be effective in relieving neuropathic pain of different etiologies in a small trial. While bupropion has shown some efficacy in neuropathic pain, there is no evidence of efficacy in patients with non-neuropathic chronic low back pain. 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 an SNRI. The efficacy of this medication was not reported. Also, the request does not indicate a frequency for the medication. Therefore, it is not medically necessary.

**Remeron 15mg #90 with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guideline (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13-14.

**Decision rationale:** The request for Remeron 15 mg quantity of 90 with 2 refills is not medically necessary. This medication is in the same class as bupropion. The California Medical Treatment Utilization Schedule states antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. It has been suggested that if pain is remission for 3 to 6 months, a gradual tapering of antidepressants may be undertaken. Antidepressants for neuropathic pain are recommended as a first line option, especially if pain is accompanied by insomnia, anxiety, or depression. For non-neuropathic pain, it is recommended as an option in depressed patients, but effectiveness is limited. Non-neuropathic pain is generally treated with analgesics and anti-inflammatories. For the treatment of low back pain, a systematic review indicated that tricyclic antidepressants have demonstrated a small to moderate effect in chronic low back pain, but the effect on function is unclear. This effect appeared to be based on inhibition of norepinephrine reuptake. Selective serotonin reuptake inhibitors (SSRIs) have not been shown to be effective for low back pain (there was not a significant difference between SSRIs and placebo) and SNRIs have not been evaluated for this condition. For the treatment of radiculopathy, antidepressants are an option, but there are no specific medications that have been proven in high quality studies to be efficacious for treatment of lumbosacral radiculopathy. For the treatment of osteoarthritis, there have been no studies with the use of antidepressants to treat pain from osteoarthritis. In depressed patients with osteoarthritis, improving depression symptoms was found to decrease pain and improve functional status. The efficacy of this medication was not reported. Also, the request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

**Clonazepam 1mg #30 with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guideline (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepine Page(s): 24.

**Decision rationale:** The request for Clonazepam 1 mg quantity of 30 with 2 refills is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines do not recommend the use of benzodiazepines as treatment for patients with chronic pain for longer than 3 weeks due to a high risk of psychological and physiological dependency. The clinical documentation submitted for review does provide evidence that the injured worker has been on this medication for an extended duration of time. Therefore, continued use would not be supported. Also, the request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

**Duragesics 25mcg/hr #10:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (Fentanyl), Ongoing Management, Opioid Dosing Page(s): 44, 78,86.

**Decision rationale:** The request for Duragesic 25 mcg/hour quantity of 10 is not medically necessary. The California Medical Treatment Utilization Guidelines indicate that Duragesic (fentanyl) is not recommended as a first line therapy. The Food and Drug Administration (FDA) approved product labeling states that Duragesic is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the injured worker is being monitored for aberrant drug behavior and side effects. The cumulative dosing of all opioids should not exceed 120 mg oral morphine equivalents per day. The request submitted does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

**Duragesics 100mcg/hr #10:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (Fentanyl), Ongoing anagement, Opioid Page(s): 44, 78,86.

**Decision rationale:** The request for Duragesic 100 mcg/hour quantity of 10 is not medically necessary. The California Medical Treatment Utilization Guidelines indicate that Duragesic (fentanyl) is not recommended as a first line therapy. The Food and Drug Administration (FDA) approved product labeling states that Duragesic is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the injured worker is being monitored for aberrant drug behavior and side effects. The cumulative dosing of all opioids should not exceed 120 mg oral morphine equivalents per day. The request submitted does not indicate a frequency for the medication. Therefore, the request is not medically necessary.