MAXIMUS Federal Services

Case Number:	CM14-0145897		
Date Assigned:	09/12/2014	Date of Injury:	05/07/2007
Decision Date:	11/10/2014	UR Denial Date:	09/03/2014
Priority:	Standard	Application Received:	09/08/2014

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 Internal 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 39 years old female, with a date of injury on 05/07/2007. The mechanisms of injury were not provided. The injured worker's diagnoses included status Post Spinal Cord Stimulator, Status Post L4-S1 Decompression and Fusion 05/01/2008 and Intractable Pain syndrome. Past treatments included medications, daily exercise and stretching. Diagnostic studies were not provided within the documentation provided for review. Surgical history includes Spinal Cord stimulator, L4-S1 Decompression and Fusion dated 05/01/2008. The clinical noted dated 08/14/2014, indicated the injured worker complained of right sided lower back pain and right lower extremity pain, rated at 5/10 with medication and 8/10 without medication. The injured worker indicated medications were effective, and reports no significant changes since previous visit. The physician indicated the patient ambulates without the use of a device and gait is described as normal. Physical exam of the lumbar spine reveals surgical scar, range of motion was revealed to be restricted with flexion, extension, right lateral bending and left lateral bending. The paravertebral muscles were noted to present with tenderness, and negative straight leg raising bilaterally, motor strength normal and sensory noted to be grossly intact without deficits. The injured worker's medications regimen included Provigil, Robaxin, Suboxone, Tegretol, Amitrptyline Hcl, Pistil, Lyrica and Topamax. The treatment plan included for Provigil 100 mg tablet 1 by mouth daily, #30, refills 5; Suboxone 8 mg-2mg tablet Sl 1 by mouth daily, #30, refill 1; Tegretol 200 mg 1 tab by mouth at bedtime #30, refills 5; Amitriptyline Hcl 100 mg tablet 2 by mouth at bedtime, #60, refills 5; Pristiq 50 mg tablet 1-2 by mouth daily, #60, refills x 5; Lyrica 100 mg capsule 1 by mouth twice a day, #60, refills 5; Robaxin 750 mg 1 tablet by mouth four times a day, #120, refills 5, Topamax 50 mg tablet 1 by mouth at bedtime, #30, refills 5. According to injured worker, medications are working well. Pattern of medication use is as previously prescribed. The rationale for request was not provided.

The request for authorization for Provigil 100 mg tablet 1 by mouth daily, #30, refills 5/ suboxone 8 mg-2 mg tablet Sl 8-2 1 by mouth daily, #30, refill 1; Tegretol 200 mg tablet 1 by mouth at bedtime, #30, refills 5; Amitriptyline Hcl 100 mg 2 by mouth at bedtime, #60, refills 5; Pristiq 50 mg tablet 1-2 by mouth daily, #60, refill 5; Lyrica 100 mg capsule, 1 by mouth twice a day, #60, refills 5; Robaxin 750 mg tablet 1 by mouth four times a day, #120, refills 5; Topamax 50 mg tablet, 1 by mouth a bedtime, 330, refills 5 was submitted on 08/14/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Provigil 100mg #30 fre 5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS: Medications for chronic pain.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Modafinil (Provigil)

Decision rationale: The request for Provigil 100 mg #30 ref 5 is not medically necessary. The California MTUS/ACOEM guidelines do not address the request. The Official Disability Guidelines states Provigil is the approved by the FDA for the treatment of narcolepsy. Prescribers using Provigil for sedation effects of opiate should consider reducing the dose of opiates before adding stimulants. Provigil is indicated to improve wakefulness in adult patients with excessive sleepiness associated with narcolepsy, obstructive sleep apnea, and shift work sleep disorder. Patients should have a complete evaluation with a diagnosis made in accordance with the International Classification of Sleep Disorders or DSM diagnostic classification. Documentation does not indicate a sleep disorder diagnosis. Furthermore, the request as submitted failed to provide the frequency and directions for use. As such, the request for Provigil 100 mg #30 ref 5 is not medically necessary.

Suboxone 8-2mg S1 #30 ref 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS: Medications for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-going Management Page(s): 78.

Decision rationale: The request for Suboxone 8-2 mg S1 #30 ref 1 is not medically necessary. The California MTUS guidelines recommend the ongoing management of opiods should include the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. The clinical information provided for review lacks documentation of the ongoing review of pain relief, functional status, appropriate

medication use and side effects. Furthermore, the request as submitted failed to provide the frequency and directions for use. As such, the request for Suboxone 8-2mg S1 #30 ref 1 is not medically necessary.

Tegretol 200mg #30 ref 5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS: Medications for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Specific Anti-Epilepsy Drugs Page(s): 18-21.

Decision rationale: The request for Tigerton 200 mg #30 ref 5 is not medically necessary. As per California MTUS guidelines, Tegretol has been shown to be effective for trigeminal neuralgia (Backonja, 2002) (ICSI, 2007) (Finnerup, 2005) and has been FDA approved for this indication. Documentation does not indicate diagnosis for trigeminal neuralgia. Furthermore, the request as submitted failed to provide the frequency and directions for use. As such, the request for Tegretol 200 mg #30 ref 5 is not medically necessary.

Amitriptyline HCL 100mg #60 ref 60 ref 5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS: Medications for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 15.

Decision rationale: The request for Amitriptyline HCL 100 mg #60 refill 5 is not medically necessary. The California MTUS guidelines indicate that tricyclic antidepressants are recommended over selective serotonin reuptake inhibitors, unless adverse reactions are a problem, Caution is required because tricyclic have a low threshold for toxicity, and tricyclic antidepressant overdose is a significant cause of fatal drug poisoning due to their cardiovascular and neurological effects. This class of medications work in both patients with normal mood and patients with depressed mood when used in treatment for neuropathic pain. Indications in controlled trials have shown effectiveness in treating central post-stroke pain, post-herpetic neuralgia, painful diabetic and non-diabetic polyneuropathy and post-mastectomy pain. Negative results were found for spinal cord pain and phantom-limb pain. The physical examination of lumbar spine, revealed range of motion to be restricted with flexion, extension, right lateral bending and left lateral bending. The injured worker presented with negative straight leg raise bilaterally. The clinical information provided for review lacks documentation related to the injured worker suffering from post-stroke pain, herpetic neuralgia or diabetic painful neuropathy. There is a lack of documentation related to the functional and therapeutic benefit in the continued use of Amitriptyline. Furthermore, the request as submitted failed to provide the frequency and directions for use. Therefore, the request for Amitriptyline HCL 100 mg #60 ref 60 ref 5 is not medically necessary.

Pristiq 50mg #60 ref 5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS: Medications for chronic pain.

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

Decision rationale: The request for Pristiq 50 mg # 60 ref 5 is not medically necessary. The California MTUS guidelines recommend antidepressants 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 analgesic medication, sleep quality andduration, and psychological assessment. Side effects, including excessive sedation should be assessed. It is recommended that these outcome measurements should be initiated at one week of treatment with a recommended trial of at least 4 weeks. The clinical information lacks documentation indicating a diagnosis for depression and neuropathic pain. There is a lack of documentation in the evaluation of function, sleep quality, duration and psychological assessment. Furthermore, the request as submitted failed to provide frequency and directions for use. As such, the request for Pristiq 50 mg #60 ref 5 is not medically necessary.

Lyrica 100mg #60 ref 5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS: Medications for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Specific Anti-epilepsy Drug Page(s): 18.

Decision rationale: The request for Lyrica 100 mg #60 ref 5 is not medically necessary. According to California MTUS guidelines, Lyrica has been documented to be effective in treatment of diabetic neuropathy and post herpetic neuralgia. Documentation does not indicate diagnosis for neuropathy or post herpetic neuralgia. Furthermore, the request as submitted failed to provide frequency and directions for use. As such, the request for Lyrica 100 mg #60 ref 5 is not medically necessary.

Robaxin 750 #120 ref 5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS: Medications for chronic pain.

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

Decision rationale: The request for Robaxin 750 #120 ref 5 is not medically necessary. The California MTUS guidelines, recommend non-sedating muscle relaxants with caution as a

second-line option for short -term treatment of acute exacerbations in patients with chronic low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most low back pain cases, they show no benefit beyond non-steroidal anti-inflammatory drugs in pain and overall improvement. The clinical information provided for review lacks documentation related to the functional and therapeutic benefit in the ongoing use of Robaxin. The ongoing use of Robaxin exceeds the recommended guidelines. In addition, the request as submitted failed to provide frequency and directions for use. As such, the request for Robaxin 750 mg #120, ref 5 is not medically necessary.

Topamax 50mg #30 ref 5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS: Medications for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Other Antiepileptic Drugs Page(s): 16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) <Insert Section (for example Knee)>, <Insert Topic (for example Total Knee Arthroplasty))>

Decision rationale: The request for Topamax 50 mg #30 ref 5 is not medically necessary. The California MTUS guidelines, recommend antiepileps drugs for neuropathic pain. There is a lack of expert consensus on the treatment of neuropathic pain in general due to heterogeneous etiologies, symptoms, physical signs and mechanisms. The documentation provided for review did not indicate the patient suffered from neuropathic pain, as there is a lack of documentation related to the injured worker's functional or neurological deficits. In addition, the request as submitted failed to provide frequency and directions for use. As such, the request for Topamax 50 mg #30 ref 5 is not medically necessary.