

Case Number:	CM14-0211833		
Date Assigned:	01/02/2015	Date of Injury:	07/13/1999
Decision Date:	02/25/2015	UR Denial Date:	12/12/2014
Priority:	Standard	Application Received:	12/17/2014

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. 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: New Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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:

The patient is a 57-year-old man who sustained a work-related injury on July 13, 1999. Subsequently, he developed chronic neck and low back pain. EMG study of the upper and lower extremities performed on June 11, 2013 documented a right C6, C7 radiculopathy, bilateral carpal tunnel syndrome, and ulnar neuropathy. Right L5 radiculopathy. According to the progress report dated from November 17, 2014 the patient continued to have significant ongoing pain in his neck with severe cervicogenic headaches, along with radicular symptoms to both upper extremities. He rated his pain as a 10/10 in intensity. The patient was becoming more and more depressed. The patient was noted to have multilevel disc disease on MRI of March 14, 2011, but a recent CT myelogram performed on May 30, 2013 revealed that the most significant pathology was at C5-6 with severe lateral recess and foraminal stenosis, which was consistent with the patient's clinical findings. The patient is going to proceed with a C5-6 fusion for severe bilateral foraminal narrowing and disc degeneration. This was certified, but the patient's health was an issue. The etiology of his headaches was likely a combination of stress, anxiety, TMJ as well as cervicogenic in origin. The patient did have elements of a cervical spine dystonia from the severe degenerative changes causing continuous muscle spasms. On February 18, 2013, the patient did receive 100 units of botulinum toxin, which significantly decreased the headaches symptoms by 60-70%. The patient continued to complain of low back pain as well as radicular symptoms in the form of weakness and numbness in both lower extremities. The patient has been requesting trigger point injections since they consistently provided a good 50% relief. Cervical spine examination revealed tenderness to palpation along the posterior cervical musculature

bilaterally and increased muscle rigidity, with decreased range of motion. The patient was able to bend his chin forward and extension was limited to 20 degrees. He had pain with both maneuvers. Examination of the right shoulder revealed tenderness to palpation along the shoulder joint line but no shoulder subluxation was appreciated. He has a decreased range of motion to shoulder abduction to about 90 degrees in comparison to the left, which was within functional limits. The patient had decreased sensation along the posterolateral forearm as well as the second, third, and fourth digits bilaterally. Intrinsic muscle wasting was noted. Deep tendon reflexes were 2/4 in the upper extremities bilaterally. Examination of the lumbar spine revealed significant increased muscle rigidity and diffuse trigger points along the lumbar paraspinal muscles. He had a decreased range of motion. He had difficulty bending since he would occasionally lose his balance. His range of motion in forward flexion was at least 6 inches from his knees and extension was limited to only 10 degrees. He had pain with both maneuvers. Motor testing in the lower extremities was between 3 to 3+/5. He used rigid knee braces bilaterally. He had decreased sensation along the posterolateral thighs and posterolateral calves bilaterally. Deep tendon reflexes were in the patella and Achilles bilaterally. The patient had 1 to 2 beats of ankle clonus noted bilaterally, which caused radicular pain. The patient was diagnosed with lumbar post laminectomy syndrome; failed back syndrome status post regional anterior and posterior fusion of lumbar spine, July 16, 2002 and revision, complicated by postoperative infection; history of spinal cord stimulation implantation complicated by MRSA infection with subsequent removal, May 2006; cervical myoligamentous injury and bilateral upper extremity radicular symptoms; right shoulder internal derangement status post arthroscopic surgery, March 15, 2000; medication induced gastritis with chronic nausea; and depression, anxiety, and insomnia. The provider requested authorization for Ambien, Abilify, Seroquel, Wellbutrin, and Xanax.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 10mg #30: 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)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Non-Benzodiazepine sedative-hypnotics (Benzodiazepine-receptor agonists)
<http://worklossdatainstitute.verioiponly.com/odgtwc/pain.htm>

Decision rationale: According to the Official Disability Guidelines, "Non-Benzodiazepine sedative-hypnotics (Benzodiazepine-receptor agonists): First-line medications for insomnia. This class of medications includes Zolpidem (Ambien and Ambien CR), Zaleplon (Sonata), and Eszopiclone (Lunesta). Benzodiazepine-receptor agonists work by selectively binding to type-1 benzodiazepine receptors in the CNS. All of the benzodiazepine-receptor agonists are schedule IV controlled substances, which means they have potential for abuse and dependency." Ambien is not recommended for long-term use to treat sleep problems. Furthermore, there is no documentation of the use of non pharmacologic treatment for the patient's sleep issue. There is

no documentation and characterization of recent sleep issues with the patient. Therefore, the prescription of Ambien 10mg #30 is not medically necessary.

Abilify 5mg #30: 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) Atypical antipsychotics, <http://www.worklossdatainstitute.verioiponly.com/odgtwc/stress.htm>

Decision rationale: According to Official Disability Guidelines, atypical antipsychotics such as (Abilify), "Not recommended as a first-line treatment. There is insufficient evidence to recommend atypical antipsychotics (eg, quetiapine, risperidone) for conditions covered in Official Disability Guidelines. See PTSD pharmacotherapy. Adding an atypical antipsychotic to an antidepressant provides limited improvement in depressive symptoms in adults, new research suggests. The meta-analysis also shows that the benefits of antipsychotics in terms of quality of life and improved functioning are small to nonexistent, and there is abundant evidence of potential treatment-related harm. The authors said that it is not certain that these drugs have a favorable benefit-to-risk profile. Clinicians should be very careful in using these medications. (Spielmans, 2013) The American Psychiatric Association (APA) has released a list of specific uses of common antipsychotic medications that are potentially unnecessary and sometimes harmful. Antipsychotic drugs should not be first-line treatment to treat behavioral problems. Antipsychotics should be far down on the list of medications that should be used for insomnia, yet there are many prescribers using quetiapine (Seroquel), for instance, as a first line for sleep, and there is no good evidence to support this. Antipsychotic drugs should not be first-line treatment for dementia, because there is no evidence that antipsychotics treat dementia. (APA, 2013) Antipsychotic drugs are commonly prescribed off-label for a number of disorders outside of their FDA-approved indications, schizophrenia and bipolar disorder. In a new study funded by the National Institute of Mental Health, four of the antipsychotics most commonly prescribed off label for use in patients over 40 were found to lack both safety and effectiveness. The four atypical antipsychotics were aripiprazole (Abilify), olanzapine (Zyprexa), quetiapine (Seroquel), and risperidone (Risperdal). The authors concluded that off-label use of these drugs in people over 40 should be short-term, and undertaken with caution. (Jin, 2013)." There is not enough documentation and evidence to support the use of an atypical antipsychotic for the treatment of patient's condition. There is no documented efficacy for previous use of Abilify. Therefore, the request for Abilify 5mg is not medically necessary.

Seroquel 200mg #60: 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) Atypical antipsychotics, <http://www.worklossdatainstitute.verioiponly.com/odgtwc/stress.htm>

Decision rationale: According to Official Disability Guidelines, atypical antipsychotics such as (Seroquel), "Not recommended as a first-line treatment. There is insufficient evidence to recommend atypical antipsychotics (eg, quetiapine, risperidone) for conditions covered in Official Disability Guidelines. See PTSD pharmacotherapy. Adding an atypical antipsychotic to an antidepressant provides limited improvement in depressive symptoms in adults, new research suggests. The meta-analysis also shows that the benefits of antipsychotics in terms of quality of life and improved functioning are small to nonexistent, and there is abundant evidence of potential treatment-related harm. The authors said that it is not certain that these drugs have a favorable benefit-to-risk profile. Clinicians should be very careful in using these medications. (Spielman, 2013) The American Psychiatric Association (APA) has released a list of specific uses of common antipsychotic medications that are potentially unnecessary and sometimes harmful. Antipsychotic drugs should not be first-line treatment to treat behavioral problems. Antipsychotics should be far down on the list of medications that should be used for insomnia, yet there are many prescribers using quetiapine (Seroquel), for instance, as a first line for sleep, and there is no good evidence to support this. Antipsychotic drugs should not be first-line treatment for dementia, because there is no evidence that antipsychotics treat dementia. (APA, 2013) Antipsychotic drugs are commonly prescribed off-label for a number of disorders outside of their FDA-approved indications, schizophrenia and bipolar disorder. In a new study funded by the National Institute of Mental Health, four of the antipsychotics most commonly prescribed off label for use in patients over 40 were found to lack both safety and effectiveness. The four atypical antipsychotics were aripiprazole (Abilify), olanzapine (Zyprexa), quetiapine (Seroquel), and risperidone (Risperdal). The authors concluded that off-label use of these drugs in people over 40 should be short-term, and undertaken with caution. (Jin, 2013)." There is not enough documentation and evidence to support the use of an atypical antipsychotic for the treatment of patient's condition. There is no documented efficacy for previous use of Seroquel. Therefore, the request for Seroquel 200mg is not medically necessary.

Wellbutrin 150mg #60: 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 Bupropion Page(s): 16.

Decision rationale: According to MTUS Chronic Pain Medical Treatment Guidelines, Wellbutrin (Bupropion) showed some efficacy in the treatment of neuropathic pain. However, there is no evidence of its effectiveness in chronic neck and back pain. Based on the above, the prescription of Wellbutrin 150MG is not medically necessary.

Xanax 1mg #120: 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 Benzodiazepines Page(s): 24.

Decision rationale: According to MTUS Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long term use for pain management because of unproven long term efficacy and because of the risk of dependence. Most guidelines limit their use to 4 weeks. There is a report of anxiety and depression and the use and failure of antidepressant was not documented. Therefore the use of Xanax 1mg is not medically necessary.