MAXIMUS Federal Services

Case Number:	CM15-0170925		
Date Assigned:	09/11/2015	Date of Injury:	04/15/2005
Decision Date:	10/16/2015	UR Denial Date:	08/25/2015
Priority:	Standard	Application Received:	08/31/2015

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: California, District of Columbia, Maryland
Certification(s)/Specialty: Anesthesiology, Pain Management

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 is a 54-year-old male with a date of injury of April 15, 2005. A review of the medical records indicates that the injured worker is undergoing treatment for mood disorder, pain disorder, insomnia, and ulnar neuropathy. A note of psychiatric preliminary findings (August 18, 2015, with an evaluation date noted to be August 13, 2015) indicates that the injured worker was diagnosed with mood disorder and pain disorder, and that he was temporarily very disabled. There was no evaluation report from the date of service on the preliminary findings. A progress note dated July 27, 2015 notes subjective complaints of constant pain in both shoulders, both wrists, and both elbows rated at a level of 6 to 8 out of 10 without medications. The injured worker also complained of feeling severely depressed and having moderate difficulty sleeping. A mental health follow up report dated December 9, 2014 notes a change in the injured worker's depression since increasing the dosage of Effexor, improved suicidal ideation, and still having some insomnia. Physical examination showed pleasant, cooperative behavior, mostly euthymic mood, normal speech, coherent, relevant, and logical though processes, no psychotic or inappropriate thought content, average insight, and unimpaired judgment. There was no recent psychological evaluation submitted for review. Treatment has included medications (Effexor since at least December of 2014; lamotrigine since at least December of 2014; Remeron since at least December of 2014; Ambien since at least December of 2014; Diazepam since at least December of 2014), treatment for physical complaints, and psychotherapy. The original utilization review (August 25, 2015) non-certified a request for Effexor XR 50mg #30 with 3 refills, Lamotrigine 50mg #60 with 3 refills, and Diazepam 10mg #90 with 3 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Effexor XR 50mg #30 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress, Antidepressants for treatment of MDD.

Decision rationale: The MTUS is silent on the treatment of major depressive disorder. Per the ODG guidelines with regard to antidepressants: Recommended for initial treatment of presentations of Major Depressive Disorder (MDD) that are moderate, severe, or psychotic, unless electroconvulsive therapy is part of the treatment plan. Not recommended for mild symptoms. Professional standards defer somewhat to patient preference, allowing for a treatment plan for mild to moderate MDD to potentially exclude antidepressant medication in favor of psychotherapy if the patient favors such an approach. (American Psychiatric Association, 2006) The requested medication is indicated for the injured worker's depression. However, the request for 50mg is not concordant with the medical records which indicate that the injured worker had increased to 75mg and then to 150mg dosage. The request is not medically necessary.

Lamotrigline 50mg #60 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: Per the MTUS guidelines with regard to anti-epilepsy drugs: Recommended for neuropathic pain (pain due to nerve damage. (Gilron, 2006) (Wolfe, 2004) (Washington, 2005) (ICSI, 2005) (Wiffen-Cochrane, 2005) (Attal, 2006) (Wiffen-Cochrane, 2007) (Gilron, 2007) (ICSI, 2007) (Finnerup, 2007) There is a lack of expert consensus on the treatment of neuropathic pain in general due to heterogeneous etiologies, symptoms, physical signs and mechanisms. Most randomized controlled trials (RCTs) for the use of this class of medication for neuropathic pain have been directed at postherpetic neuralgia and painful polyneuropathy (with diabetic polyneuropathy being the most common example). There are few RCTs directed at central pain and none for painful radiculopathy. (Attal, 2006) The choice of specific agents reviewed below will depend on the balance between effectiveness and adverse reactions. See also specific drug listings below: Gabapentin (Neurontin); Pregabalin (Lyrica); Lamotrigine (Lamictal); Carbamazepine (Tegretol); Oxcarbazepine (Trileptal); Phenytoin (Dilantin); Topiramate (Topamax); Levetiracetam (Keppra); Zonisamide (Zonegran); & Tiagabine

(Gabitril) Outcome: A "good" response to the use of AEDs has been defined as a 50% reduction in pain and a "moderate" response as a 30% reduction. It has been reported that a 30% reduction in pain is clinically important to patients and a lack of response of this magnitude may be the "trigger" for the following: (1) a switch to a different first-line agent (TCA, SNRI or AED are considered first-line treatment); or (2) combination therapy if treatment with a single drug agent fails. (Eisenberg, 2007) (Jensen, 2006) After initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. AEDs are associated with teratogenicity, so they must be used with caution in woman of childbearing age. Preconception counseling is recommended for anticonvulsants (due to reductions in the efficacy of birth control pills). (Clinical Pharmacology, 2008) With specific regard to Lamictal: Lamotrigine (Lamictal, generic available) has been proven to be moderately effective for treatment of trigeminal neuralgia, HIV, and central post-stroke pain; (Backonja, 2002) (Namaka, 2004) (Maizels, 2005) (ICSI, 2005) (Dworkin, 2003) (Wiffen-Cochrane, 2007). It has not been shown to be effective for diabetic neuropathy. Due to side effects and slow titration period, lamotrigine is not generally recommended as a first-line treatment for neuropathic pain. (Dworkin, 2003) (ICSI, 2007) Furthermore, a recent Cochrane review determined that although there is some evidence that lamotrigine may be effective for HIV neuropathy and post-stroke pain, this drug does not have a "significant place in therapy at present." This was partly due to the availability of more effective treatments including other AEDs and antidepressants. (WiffenCochrane, 2007) The documentation submitted for review indicates that the injured worker reported slight improvement with his pain. Per progress report dated 7/27/15, it was noted that the injured worker had greater than 70%-80% improvement in both his overall pain and ability to function with his current medications. An AED is indicated for the injured worker's neuropathic pain; however, there was no rationale as to why a first-line AED is not prescribed. There is no evidence of biploar disorder for which lamotrigine may be indicated. Furthermore, the request for 4-month supply is not appropriate, as it does not allow for timely reassessment of efficacy. The request is not medically necessary.

Diazepam 10mg #90 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

Decision rationale: Per MTUS Chronic Pain Medical Treatment Guidelines p 24 regarding benzodiazepines, "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. The documentation submitted for review indicates that the injured worker has been using this medication since at least 12/2013. As the treatment is not recommended for long-term use, the request is not medically necessary. Furthermore, the request for 4-month supply is not appropriate, as it does not allow for timely reassessment of efficacy.