

Case Number:	CM15-0033354		
Date Assigned:	02/26/2015	Date of Injury:	01/07/2011
Decision Date:	05/18/2015	UR Denial Date:	02/11/2015
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: New Jersey, Alabama, 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 injured worker is a 34 year old male, who sustained an industrial injury on January 7, 2011. He reported neck pain, back pain, upper and lower extremity pain with associated tingling and numbness, left knee pain and emotional stress. The injured worker was diagnosed as having post-accident headaches, discopathy of the cervical spine with radiculopathy in the right upper extremity, herniated discs of the lumbar spine with nerve impingement in bilateral lower extremities worse on the right side and internal derangement of the left knee, mood disorder, stress affective disorder, affective psychosis, attention deficit disorder and work related emotional stress. Treatment to date has included diagnostic studies, psychotherapy, medications and work restrictions. Currently, the injured worker complains of intense anger and anxiety, insomnia and depression, neck pain, back pain, upper and lower extremity pain with associated tingling and numbness and left knee pain and emotional stress. The injured worker reported an industrial injury in 2011, resulting in the above noted pain. He was treated with medications and psychotherapy without complete resolution of the pain. Evaluation on October 21, 2011, revealed continued emotions as noted. Medications were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Olanzapine (Zyprexa) tab 10mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. 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 Atypical antipsychotics.
<http://www.worklossdatainstitute.verioiponly.com/odgtwc/stress.htm>.

Decision rationale: According to ODG guidelines, atypical antipsychotics such as Olanzapine "Not recommended as a first-line treatment. There is insufficient evidence to recommend atypical antipsychotics (e.g., quetiapine, risperidone) for conditions covered in ODG. 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 continuous use of an atypical antipsychotic for the treatment of the patient's condition. The patient has been using atypical antipsychotics treatments since at least 2011 with no evidence of functional improvement and efficacy. Therefore, the request for Olanzapine (Zyprexa) tab 10mg #30 is not medically necessary.

Quetiapine (Seroquel) tab 25mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. 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 Atypical antipsychotics.
<http://www.worklossdatainstitute.verioiponly.com/odgtwc/stress.htm>.

Decision rationale: According to ODG guidelines, atypical antipsychotics such as Quetiapine "Not recommended as a first-line treatment. There is insufficient evidence to recommend atypical antipsychotics (e.g., quetiapine, risperidone) for conditions covered in ODG. 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 continuous use of an atypical antipsychotic for the treatment of the patient's condition. The patient has been using atypical antipsychotics treatments since at least 2011 with no evidence of functional improvement and efficacy. Therefore, the request for Quetiapine (Seroquel) tab 25mg #60 is not medically necessary.

Oxcarbazepin (Trileptal) tab 150mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-17.

Decision rationale: According to MTUS guidelines, anti epileptic 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). There is no documentation that the patient is suffering from severe neuropathic pain. Furthermore, there is no documentation that the patient failed first line anti-epileptic drugs such as Neurontin. Therefore, the request to use Oxcarbazepin (Trileptal) tab 150mg #90 is not medically necessary.