

Case Number:	CM15-0073948		
Date Assigned:	04/24/2015	Date of Injury:	07/03/2014
Decision Date:	05/27/2015	UR Denial Date:	04/03/2015
Priority:	Standard	Application Received:	04/17/2015

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: Pennsylvania
 Certification(s)/Specialty: Internal 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 53-year-old male who sustained an industrial injury on 7/3/14 due to a fall. The injured worker has complaints of neck and low back pain, dizziness, and post-traumatic headaches. The diagnoses have included post- concussion syndrome, cervical strain, lumbar strain, depression/anxiety, and headaches. Evaluation has included computed tomography scan of the brain, magnetic resonance imaging (MRI) of the cervical and lumbar spine, and cervical spine x-ray. MRIs showed disc protrusions. Treatment to date has included acupuncture, medication, cognitive behavioral therapy, physical therapy, and chiropractic treatment. On 10/22/14, the injured worker reported ongoing headaches, intermittent, nausea, frequent dizziness, intermittent blurry vision, poor sleep, and neck and lower back pain. Headaches were rated 5/10 in severity, neck pain 7/10 in severity, and low back pain 5-6/10 in severity. Examination showed tenderness of the paraspinal muscles in the neck and lumbar areas, and normal neurological examination. Relafen and ultracet were prescribed for pain and Topamax was prescribed for headache symptoms. A urine toxicology screen was noted to be consistent. Work status was noted as off work/temporarily totally disabled. Progress note of 11/4/14 notes that Relafen and ultracet, were helpful for pain and that Topamax was helpful for pain and sleep. Continued headaches, neck and back pain were noted. A psychological evaluation on 1/15/15 notes diagnoses of major depressive disorder, anxiety disorder, and mild traumatic brain injury. Progress note of 3/17/15 states that mirtazapine has been used for dizziness and insomnia. Ongoing daily headaches, intermittent nausea, frequent dizziness, neck pain, and low back pain were reported. Current medications include Relafen, ultracet, mirtazapine, Topamax, and

meclizine. On 4/3/15, Utilization Review (UR) non-certified requests for Topairamax, nabumetone, tramadol/APAP, and mirtazapine, citing the MTUS, ODG, and additional medical literature.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro: Topiramate-topamax 25mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines anti-epilepsy drugs Page(s): 16-21.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines anticonvulsants Page(s): 16-22.

Decision rationale: Per the MTUS, antiepilepsy drugs (AEDs) are recommended for neuropathic pain due to nerve damage. Topamax has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of "central" etiology. It is still considered for use for neuropathic pain when other anticonvulsants fail. A "good" response to the use of AEDs is defined as a 50% reduction in pain and a "moderate" response as a 30% reduction. Lack of at least a 30% response per the MTUS would warrant a switch to a different first line agent or combination therapy. After initiation of treatment, there should be documentation of pain relief with improvement in function, and documentation of any side effects, with continued use of AEDs dependent on improved outcomes versus tolerability of adverse effects. In this case, topamax was noted to be prescribed for headaches. Topamax was noted to be helpful for pain and sleep, but ongoing headaches were documented. There was no documentation of at least a 30% reduction in pain or headaches as a result of use of topamax. There was no documentation of functional improvement as a result of use of topamax: return to work was not documented, and there was no discussion of improvement in activities of daily living or reduction in medication use. Due to lack of demonstration of significant improvement in pain or improvement in function as a result of topamax, the request for topamax is not medically necessary.

Retro: Nabumetone-relafen 500mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 72-73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67-73.

Decision rationale: This injured worker has chronic neck and back pain, and headaches. Relafen has been prescribed for at least 5 months. Per the MTUS, nonsteroidal anti-inflammatory drugs (NSAIDs) are recommended as a second line treatment after acetaminophen for treatment of acute exacerbations of chronic back pain. The MTUS does not specifically reference the use of NSAIDs for long-term treatment of chronic pain in other specific body parts. NSAIDs are noted to have adverse effects including gastrointestinal side effects and increased cardiovascular risk;

besides these well-documented side effects of NSAIDs, NSAIDs have been shown to possibly delay and hamper healing in all the soft tissues including muscles, ligaments, tendons, and cartilage. NSAIDs can increase blood pressure and may cause fluid retention, edema, and congestive heart failure; all NSAIDs are relatively contraindicated in patients with renal insufficiency, congestive heart failure, or volume excess. They are recommended at the lowest dose for the shortest possible period in patients with moderate to severe pain. The MTUS does not recommend chronic NSAIDs for low back pain; NSAIDs should be used for the short term only. Systemic toxicity is possible with NSAIDs. The FDA and MTUS recommend monitoring of blood tests and blood pressure. There is no evidence that the prescribing physician is adequately monitoring for toxicity as recommended by the FDA and MTUS. Although the reports note some improvement in pain as a result of medications, there was no documentation of functional improvement as a result of use of relafen. Return to work was not noted, there was no discussion in improvement of activities of daily living, there was no documentation of decrease in medication use, and office visits have continued at the same frequency. Due to length of use in excess of the guidelines and lack of functional improvement, the request for relafen is not medically necessary.

Retro: Tramadol/APAP 37.5/325mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids
Page(s): 74-96.

Decision rationale: This injured worker has chronic headaches and chronic neck and back pain. Tramadol has been prescribed for at least 5 months. Tramadol is a centrally acting synthetic opioid analgesic, which is not recommended as a first line oral analgesic. Multiple side effects have been reported including increased risk of seizure especially in patients taking selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants (TCAs) and other opioids. It may also produce life-threatening serotonin syndrome. There is insufficient evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. None of these aspects of prescribing is in evidence. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, "mechanical and compressive etiologies," and chronic back pain. Although some pain relief was noted as a result of medications, there is no evidence of significant pain relief or increased function from the opioids used to date. Pain severity was noted at the initial office visit but was not rated in subsequent reports. Return to work was not documented, and there was no discussion of improvement in activities of daily living or reduction in medication use. The prescribing physician does not specifically address function with respect to prescribing opioids, and does not address the other recommendations in the MTUS. The MTUS states that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. There is no evidence that the treating physician has utilized a treatment plan not using opioids, and that the patient "has failed a trial of non-opioid analgesics." Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and

aberrant drug-taking behaviors. Change in activities of daily living, discussion of adverse side effects, and screening for aberrant drug-taking behaviors were not documented. The MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. There is no record of a urine drug screen program performed according to quality criteria in the MTUS and other guidelines. One urine drug screen before the onset of use of tramadol was reported, without subsequent urine drug screens. As currently prescribed, tramadol does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

Retro: Mirtazapine 15mg #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, Mental Illness & Stress, <http://www.ncbi.nlm.nih.gov/pubmed/19453203>.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 401-402. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) chronic pain chapter: insomnia treatment mental illness and stress chapter: antidepressants for treatment of major depressive disorder.

Decision rationale: Mirtazapine is an antidepressant indicated for the treatment of major depressive disorder. The documentation indicates that this injured worker has depression, which has been treated with cognitive behavioral therapy. Mirtazapine was noted to have been prescribed for insomnia and dizziness. There was limited discussion of use of mirtazapine as it relates to the injured worker's diagnosis of depression. The ACOEM notes that brief courses of antidepressants may be helpful to alleviate symptoms of depression, but that given the complexity of available agents, referral for medication evaluation is advised. The ODG states that antidepressants offer significant benefit in the treatment of the severest depressive symptoms, but may have little or no therapeutic benefit over and above placebo in patients with mild to moderate depression. The MTUS does not address the use of hypnotics other than benzodiazepines. No physician reports describe the specific criteria for a sleep disorder. Treatment of a sleep disorder, including prescribing hypnotics, should not be initiated without a careful diagnosis. There is no evidence of that in this case. For the treatment of insomnia, pharmacologic agents should only be used after careful evaluation of potential causes of sleep disturbance. Specific components of insomnia should be addressed. There was no documentation of evaluation of sleep disturbance in the injured worker, and components insomnia was not addressed. The treating physician has not addressed major issues affecting sleep in this patient, including the use of other psychoactive agents like opioids, which significantly impair sleep architecture. Due to insufficient evaluation for sleep disorder, and lack of clear documentation of use of mirtazapine for the treatment of depression without documentation of benefit for the injured worker's depression, the request for mirtazapine is not medically necessary.