

Case Number:	CM15-0095067		
Date Assigned:	05/21/2015	Date of Injury:	06/14/2009
Decision Date:	07/01/2015	UR Denial Date:	05/11/2015
Priority:	Standard	Application Received:	05/18/2015

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, Arizona, Maryland
 Certification(s)/Specialty: Psychiatry

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 56 year old female patient who sustained an industrial injury on 06/14/2009. The accident was described as having fallen with resulting injury. A primary treating office visit dated 05/11/2015 reported the patient with subjective complaint of having a slight increase in the low back pain. The pain s found radiating to the right lower extremity and accompanied by numbness, parasthesia's, and weakness to bilateral lower extremities. She is also with residual foot pain described as burning especially when walking more than 15 minutes. Objective findings showed neurologic examination revealed grade 4/5 bilateral hip flexor and abducto strength with pain inhibition. There is a grade 4/5 right hamstring and ankle dorsiflexion, inversion, eversion, and plantar flexion strength with pain inhibition. There is trace grade 2/5 right tow EHL strength. The sensory examination found global deficit to light touch and pinprick in the right lower extremity. There is also diminished vibratory sense in the right ankle. The assessment found the patient with: no functional gains including mobility since last visit; residuals of lumbar strain with underlying lumbar spondylosis; residuals of lumbar facet syndrome with radiculopathy; status post right ankle inversion sprain with talar dome lesion; status post right ankle arthroscopic surgery and peroneal tendon repair, and neuropathic pain. The diagnoses attached to this encounter were: lumbosacral spondylosis without myelopathy; lumbosacral radiculitis; unspecified site of ankle sprain, and enthesopathy of unspecified site. The plan of care noted the patient prescribed for lumbar magnetic resonance imaging ruling out L5-S1 disc protrusion; discontinued Cymbalta secondary to headaches, and was offered a right tibiotalar steroid injection of which she declined; continue Prilosec, Voltaren gel, and will

remain permanent and stationary. Back on 09/16/2014 she was with subjective complaint of further increased right ankle pain. This pain occurs when she's walking longer than 15 minutes. She is also with complaint of residual low back pain that occasionally radiates down bilateral lower extremities. There is also continued complaint of having weakness of both legs, and she still has numbness, parasthesia's. Objective findings showed the lumbar extension to 20 degrees. There is ipsilateral back pain with right side bending. There is increased lordosis, and lumbar paraspinal spasm. There is gluteal tenderness to palpation. The following tests are found positive: bilateral lumbar facet maneuver and right straight leg raise at 30 degrees. The right ankle showed right ankle arthroscopic scars. There is mild pain with inversion. There is subtalar tenderness and tibiotalar tenderness; along with right inframalleolar area tenderness. There is mild allodynia. She declined an injection. The Topamax was discontinued. She was prescribed Lyrica 50mg one TID #90 with 2 refills. She will continue Prevacid, Voltaren gel and will remain permanent and stationary. A psychiatric note dated 08/21/2014 reported the patient as unchanged. She had not been provided medication Celexa and has complaint of increased anxiety, fear and decreased sleep. She has continued complaint of being depressed. Of note, the patient is no longer taking Tramadol or Fetzima due to nausea. She underwent the Beck depression inventory scoring a twenty two. The plan of care noted the Fetzima discontinued, prescribed Celexa 20mg daily, Trazadone 50mg HS, laboratory values pending, recommending weekly cognitive behavioral psychotherapy, and follow up in two weeks. By 09/05/2014 her complaints persisted. She did report stopping the Tramadol secondary to headaches. The Beck depression inventory test resulted in a score of 31 which is indicative of severe depression. The following diagnoses are applied: adjustment disorder with depressed anxious mood, depressive disorder. She will continue with Cele xa, discontinue Trazadone, and start Silenor 3mg HS.

IMR ISSUES, DECISIONS AND RATIONALES

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

Wellbutrin 150mg #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Bupropion (Wellbutrin). Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 11th Edition (web), 2014, Mental Illness and Stress, Bupropion (Wellbutrin), Antidepressants for treatment of MDD (major depressive disorder).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topic: Bupropion Page(s): 16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Stress & Mental Illness Topic: Antidepressants for treatment of MDD (major depressive disorder).

Decision rationale: MTUS states "Bupropion (Wellbutrin(R)), a second-generation non-tricyclic antidepressant (a noradrenaline and dopamine reuptake inhibitor) has been shown to be effective in relieving neuropathic pain of different etiologies in a small trial (41 patients). (Finnerup, 2005) While bupropion has shown some efficacy in neuropathic pain there is no evidence of efficacy in patients with nonneuropathic chronic low back pain. (Katz, 2005) Furthermore, a recent review suggested that bupropion is generally a third-line medication for diabetic neuropathy and may be considered when patients have not had a response to a tricyclic or SNRI. (Dworkin, 2007) Side-

effect profile: Headache, agitation, insomnia, anorexia, weight loss Dosing Information:
Neuropathic pain (off-label indication): 100 mg once daily, increase by 100 mg per week up to
200 mg twice daily. (Maizels, 2005)" The injured worker suffers from chronic pain and
developed adjustment disorder with mixed anxiety and depressed mood and depressive disorder
secondary to the same. Per progress report 4/30/2015, the injured worker's mental status had
decompensated without the Wellbutrin and she presented as more depressed and tearful. The
request for Wellbutrin 150mg #30 is medically necessary to stabilize the symptoms. Will
respectfully disagree with UR physician's decision.