

Case Number:	CM15-0098455		
Date Assigned:	05/29/2015	Date of Injury:	03/01/2004
Decision Date:	07/03/2015	UR Denial Date:	04/28/2015
Priority:	Standard	Application Received:	05/21/2015

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: Florida

Certification(s)/Specialty: Family Practice

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 70-year-old male who sustained an industrial injury on 03/01/2004. Diagnoses include status post lumbar laminectomy at L1-L2 with a fusion at L1-L2, L4-5, and L5-S1, right L5-S1 done on 01/21/2015, radiculopathy by electromyography, bilateral greater trochanteric bursitis with right IT band syndrome, status post bilateral total knee arthroplasties with left redo gastrocnemius flap followed by chronic infection on lifelong antibiotics, bilateral carpal tunnel syndrome status post release, depression and anxiety, sleep apnea, history of right lumbar facet syndrome, and history of right lateral femoral cutaneous neuralgia. X rays done on 01/20/2015 revealed multiple compression fractures. A computed tomography of the lumbar spine done on 03/05/2015 showed status post posterior fusion from L1 through S1 with intervertebral disc spacers at L1-2, L2-3, and L3-4. There is posterior graft material noted on the left side from L3 through S1. At L1-2 there is a small focus of radii density in the right paracentral to parasagittal distribution, extending into the region of the right lateral recess and inseparable from the posterior margin of the intervertebral disc spacer and likely reflecting either posterior displacement of the spacer versus other radio dense cement-like material. There is moderately severe degenerative disc disease at L4-5 and L5-S1. There are small disc osteophytes; coccyx is with facet hypertrophy resulting in narrowing of the lateral recesses and neural foramina without obvious central canal stenosis. Treatment to date has included diagnostic studies, surgery, medications, therapy, home exercise program and home health services. A physician progress note dated 04/17/2015 documents the injured worker complains of continued low back pain and increased bilateral lower extremity radiculopathy. He has an increase in burning sensation in his bilateral anterior thighs. He is having poor control with OxyContin and Percocet. He is taking OxyContin 20mg 3 times a day, Percocet 10/325mg 4 times a day as needed, Wellbutrin XL 50mg 2 tablets every day. Lyrica 150mg 2 times a day,

and Topamax 100mg daily. He is working on increasing his walking. He ambulates with a slow gait and uses a cane. Flexion is at 30 degrees and extension is at 5 degrees. He has reproduction in the right low back pain at 90 degrees on the right side. He has moderate depression. The treatment plan includes increasing his Lyrica to 200mg twice a day to help with neuropathic symptoms, consider Electromyography nerve conduction study, continue with his home exercise program, and return visit in 10 days to evaluate the effects of Lyrica and refill medications. Treatment requested is for Lyrica 200mg, quantity: 60, OxyContin 20mg, quantity: 90, Percocet 10/325mg, quantity: 120, Topamax 100mg, quantity: 30, and Wellbutrin XL 150mg, quantity: 60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lyrica 200mg, quantity: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pregabalin (Lyrica).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lyrica Page(s): 99.

Decision rationale: MTUS guidelines state regarding Lyrica, "Pregabalin (Lyrica) has been documented to be effective in treatment of diabetic neuropathy and postherpetic neuralgia, has FDA approval for both indications, and is considered first-line treatment for both. Pregabalin was also approved to treat fibromyalgia." Regarding this patient's case, this medication is being prescribed for Neuropathic pain, however there is no documented evidence of improvement in his pain with this medication. In fact, documentation implies that the patient is actually having increased neuropathic symptoms despite this medication. Likewise, this request is not considered medically necessary.

Topamax 100mg, quantity: 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy Drugs Page(s): 21.

Decision rationale: MTUS guidelines state regarding Topiramate, "Topiramate (Topamax, no generic available) 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. Topiramate has recently been investigated as an adjunct treatment for obesity, but the side effect profile limits its use in this regard. (Rosenstock, 2007)" In this patient's case, the patient is being prescribed 3 different medications (Topiramate, Lyrica, and Wellbutrin) for the treatment of Neuropathic pain, per the documentation. The documentation does not indicate that there is any improvement with these medications in the patient's pain. Likewise, this request cannot be considered medically necessary.

Oxycontin 20mg, quantity: 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-80.

Decision rationale: In accordance with California MTUS guidelines, narcotics for chronic pain management should be continued if; (a) If the patient has returned to work, (b) If the patient has improved functioning and pain. MTUS guidelines also recommend that narcotic medications only be prescribed for chronic pain when there is evidence of a pain management contract being upheld with proof of frequent urine drug screens. Regarding this patient's case, there is no objective evidence of functional improvement with the use of this chronic narcotic medication. Likewise, this request is not considered medically necessary.

Percocet 10/325mg, quantity: 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-80.

Decision rationale: In accordance with California MTUS guidelines, narcotics for chronic pain management should be continued if; (a) If the patient has returned to work, (b) If the patient has improved functioning and pain. MTUS guidelines also recommend that narcotic medications only be prescribed for chronic pain when there is evidence of a pain management contract being upheld with proof of frequent urine drug screens. Regarding this patient's case, there is no objective evidence of functional improvement with the use of this chronic narcotic medication. Likewise, this request is not considered medically necessary.

Wellbutrin XL 150mg, quantity: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 50.

Decision rationale: MTUS guidelines state regarding Bupropion, "Bupropion (Wellbutrin), 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 non- neuropathic 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." In this patient's case, the patient is being prescribed 3 different medications (Topiramate, Lyrica, and Wellbutrin) for the treatment of neuropathic pain, per the documentation. The documentation does not indicate that there is any improvement with these medications in the patient's pain. Likewise, this request for continued use of Wellbutrin cannot be considered

medically necessary.