

<b>Case Number:</b>	CM14-0133009		
<b>Date Assigned:</b>	08/22/2014	<b>Date of Injury:</b>	12/29/2006
<b>Decision Date:</b>	10/08/2014	<b>UR Denial Date:</b>	07/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/20/2014

### 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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Patient is a 52-year-old female who has submitted a claim for post-laminectomy syndrome, lumbar region, status post bilateral L5-S1 laminectomy and posterior lateral fusion with segmental instrumentation (08/28/09); neuralgia, neuritis and radiculitis, not specified; degeneration of cervical intervertebral disc; carpal tunnel syndrome, right and left; venous stasis of the lower extremities; autonomic neurogenic bladder; and gastroesophageal reflux disease (GERD), associated with an industrial injury date of 12/29/06. Medical records from 2013 to 2014 were reviewed. Patient apparently sustained the injury when she had a blood pressure monitor fall on her back while she was bending down. She then developed an ongoing right leg radicular pain and radiculopathy in the S1 distribution. She underwent surgery of the lumbar area, however, there was noted persistence of pain. 07/10/14 progress report showed patient complains of constant aching paracervical and intrascapular pain radiating to both arms and hands, with numbness at the hands and fingers. She also reports of constant throbbing pain at the lumbosacral junction extending to both buttocks, with focus at the coccyx, as well as aching, pressing, cramping and pinching pain and numbness on both lower extremities rated as 10/10 without medications, and 5-7/10 with medications with no reported adverse events. She is noted to be on the lowest possible dose to achieve function and weaning on opioids was attempted with note of a 50% pain relief with medication enabling her to do walking, doing grocery and doing light cleaning which she wouldn't have been able to do without the medication. A urine drug screen was last done on 08/22/13 and was positive for Oxymorphone. On physical examination, there is moderate edema of the bilateral hands, ankles and feet with blotchy erythema and discoloration of the lower 1/3 of the lower extremities. Phalen's maneuver was positive on both hands; patient had an antalgic gait with a limp on the right, painful and decreased range of motion (ROM) of the lumbar area with tenderness at the lumbosacral region. Plan was to refer to

a behavioral psychologist, GI follow-up, Urological follow-up and to continue medications Treatment to date has included surgery, spinal cord stimulation, sacroiliac joint steroid injection, wrist/hand brace and medications (Prevacid, Cymbalta, Opana and Lidocaine cream since at least 2010). Utilization review date of 07/29/14 denied the request for Opana since the computed morphine dose of 300mg MED is in excess of the recommended 100mg MED. Request for Cymbalta was likewise denied because a recent psychological evaluation to determine its efficacy and appropriateness for its continued use was not provided in the submitted records, as well as absence of quality evidence to support the use of Duloxetine for lumbar radiculopathy.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Cymbalta oral CPDR 60mg #30:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Duloxetine (Cymbalta) Page(s): 43-44.

**Decision rationale:** Duloxetine (Cymbalta) is a norepinephrine and serotonin reuptake inhibitor antidepressant (SNRI). Pages 43-44 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that duloxetine is recommended as an option in first-line treatment option in neuropathic pain, as well as depression. In this case, patient's clinical manifestations are consistent with neuropathic pain. Patient likewise has mood disorder. Medical records are unclear regarding the duration of duloxetine use to date, only that it must have been used since 2010. Progress report from 07/17/2014 stated that Cymbalta improved her mood and pain. Guideline criteria were met. Therefore, the request for Cymbalta oral CPDR 60mg #30 is medically necessary.

**Oxymorphone (Opana) 10mg caps #120 oral tablet:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioid section Page(s): 74-93.

**Decision rationale:** As stated on pages 74-93 of the California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines, "there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs". Also, in general, the total daily dose of opioid should not exceed 120 mg oral morphine equivalents and only after pain management consultation, should the total daily dose of opioid be increased above 120 mg oral morphine equivalents. Criteria for

the continuation of opioid include return to work and improved pain and functioning. In this case, patient was on Opana since at least 2010. Patient reported decreased pain severity from 10/10 into 5-7/10 with medications with no reported adverse events. She is noted to be on the lowest possible dose to achieve function and weaning on opioids was attempted with note of a 50% pain. She likewise reported improved functional levels specifically when walking, going to the grocery and when doing light cleaning. Urine drug screen from 08/22/2013 likewise showed consistent results with prescribed medications. Patient likewise has had pain specialist consultations. Guideline criteria for continuing opioid management have been met. Therefore, the request for Oxymorphone (Opana) 10mg caps #120 oral tablet is medically necessary.