

<b>Case Number:</b>	CM14-0162340		
<b>Date Assigned:</b>	10/07/2014	<b>Date of Injury:</b>	10/01/2012
<b>Decision Date:</b>	11/01/2014	<b>UR Denial Date:</b>	09/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/02/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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:

The injured worker is a 52-year-old male who reported an injury on 10/01/2012. The mechanism of injury was lifting a heavy propane hose and dragging it repeatedly. The diagnoses included chronic pain syndrome, degeneration of lumbar or lumbosacral intervertebral disc, lumbosacral spondylosis, disc displacement without radiculitis, and pain in thoracic spine. The previous treatments included medication, TENS Unit, and epidural steroid injections. The diagnostic testing included an EMG/NCV. Within the clinical note dated 01/28/2014, it was reported the injured worker complained of pain in feet. He also complained of numbness bilaterally. The injured worker complained of low back pain that was bilateral over the sacral coccygeal region. The injured worker complained of pain down the right lower extremity compared to the left. He rated his pain 8/10 in severity. Upon the physical examination, the provider noted a positive straight leg raise on the left for radicular pain. There was tenderness to palpation bilaterally in the lumbar region. The injured worker had positive facet loading bilaterally. The range of motion was restricted. The provider requested Cymbalta, Trazodone for insomnia and TENS Unit for purchase. The Request for Authorization was submitted and dated 12/01/2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cymbalta 60mg #90 with 3 refills:** Upheld

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

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

**Decision rationale:** The request for Cymbalta 60 mg #90 with 3 refills is not medically necessary. The California MTUS Guidelines recommend Cymbalta as an option in first line treatment of neuropathic pain. It has FDA approval for the treatment of depression, generalized anxiety disorder, and for the treatment of pain related to diabetic neuropathy. The guidelines note antidepressants are recommended as an option for radiculopathy. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

**Trazodone 50mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Antidepressant, Page(s): 13.

**Decision rationale:** The request for Trazodone 50 mg is not medically necessary. California MTUS Guidelines recommend antidepressants as a first line option for neuropathic pain and as a possibility for non-neuropathic pain. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency and the quantity of the medication. Therefore, the request is not medically necessary.

**TENS unit purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, Page(s): 114-116.

**Decision rationale:** The request for a TENS Unit for purchase is not medically necessary. The California MTUS Guidelines do not recommend a TENS unit as a primary treatment modality. A 1 month home based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence-based functional restoration. There is evidence that other appropriate pain modalities have been tried, including medication, and failed. There is lack of documentation upon the physical examination indicating the injured worker has significant neurological deficits. The request submitted failed to provide a treatment site. It is unclear if the injured worker had undergone an adequate trial of the TENS Unit. Therefore, the request is not medically necessary.