

Case Number:	CM14-0035024		
Date Assigned:	04/30/2014	Date of Injury:	07/12/2002
Decision Date:	06/11/2014	UR Denial Date:	03/05/2014
Priority:	Standard	Application Received:	03/21/2014

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:

The patient is a 52 year old male who was injured on 02/21/2014. Mechanism of injury is unknown. The patient's medications as of 09/20/2013 include Amitriptyline HCL 25 mg, Ambien 10 mg, Suboxone 8 mg-2 mg, and Cymbalta 60 mg. Pain management note dated 02/21/2014 reports the patient is having severe symptoms in his right arm that are fluctuating. The aggravating factors include daily activities, extension, flexion, jumping, lifting, lying, pushing, standing, walking, and rolling over in the bed. The relieving factors include heat; ice, pain medication, and rest. His chronic problems include facet arthropathy, pain in the joint involving shoulder region, and cervical radiculopathy. On exam, musculoskeletal exam is positive for joint pain, joint swelling, muscle weakness, and neck pain. He does not have any back pain. He notes his pain score with medications is 9/10 and without medications an 8/10. Her UDS is current and consistent for all prescribed medications and she is due for a routine blood test today (this test was not provided for review).

IMR ISSUES, DECISIONS AND RATIONALES

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

CYMBALTA 60MG #30 WITH 4 REFILLS: 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 Selective Serotonin And Norepinephrine Reuptake Inhibitors (SNRIs): Duloxetine (Cymbalta®). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain.

Decision rationale: As per CA MTUS and ODG, it is recommended as an option in first-line treatment option in neuropathic pain. Cymbalta is a norepinephrine and serotonin reuptake inhibitor antidepressant (SNRIs) which is FDA approval for treatment of depression, generalized anxiety disorder. This is a very difficult patient with chronic pain and depression. Thus, this medication is an appropriate as per the guidelines and is medically necessary.

GABAPENTIN, SUBOXONE, AND AMITRIPTYLINE LAB TEST: 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 URINE DRUG TEST Page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain.

Decision rationale: As per CA MTUS guidelines, urine drug screening is recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. As per ODG, criteria for use of urine drug tests may be subject to specific drug screening statutes and regulations based on state and local laws, and the requesting clinician should be familiar with these. State regulations may address issues such as chain of custody requirements, patient privacy, and how results may be used or shared with employers. The rules and best practices of the U.S. Department of Transportation should be consulted if there is doubt about the legally defensible framework of most jurisdictions. (DOT, 2010) 1. A point-of-contact (POC) immunoassay test is recommended prior to initiating chronic opioid therapy. This is not recommended in acute care situations (i.e. for treatment of nociceptive pain). There should be documentation of an addiction-screening test using a formal screening survey in the records prior to initiating treatment. If the test is appropriate, confirmatory lab testing is not required. See Opioids, screening tests for risk of addiction & misuse. 2. Frequency of urine drug testing should be based on documented evidence of risk stratification including use of a testing instrument. See Opioids, tools for risk stratification & monitoring. An explanation of "low risk," "moderate risk," and "high risk" of addiction/aberrant behavior is found under Opioids, tools for risk stratification & monitoring and Opioids, screening tests for risk of addiction & misuse. 3. Patients at "low risk" of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. There is no reason to perform confirmatory testing unless the test is inappropriate or there are unexpected results. If required, confirmatory testing should be for the questioned drugs only. 4. Patients at "moderate risk" for addiction/aberrant behavior are recommended for point-of-contact screening 2 to 3 times a year with confirmatory testing for inappropriate or unexplained results. This includes patients undergoing prescribed opioid changes without success, patients with a stable addiction disorder, those patients in unstable and/or dysfunction social situations, and for those patients with comorbid psychiatric pathology. 5. Patients at "high risk" of adverse outcomes may require testing as often as once per month. This category generally includes individuals with active substance abuse disorders. 6. If a urine

drug test is negative for the prescribed scheduled drug, confirmatory testing is strongly recommended for the questioned drug. If negative on confirmatory testing the prescriber should indicate if there is a valid reason for the observed negative test, or if the negative test suggests misuse or non-compliance. Additional monitoring is recommended including pill counts. Recommendations also include measures such as prescribing fewer pills and/or fewer refills. A discussion of clinic policy and parameters in the patient's opioid agreement is recommended. Weaning or termination of opioid prescription should be considered in the absence of a valid explanation. See Opioids, dealing with misuse & addiction. 7. If a urine drug test is positive for a non-prescription. If a urine drug test is positive for a non-prescribed scheduled drug or illicit drug, lab confirmation is strongly recommended. In addition, it is recommended to obtain prescription drug monitoring reports. If there is evidence of problems with cross-state border drug soliciting in your area, reports from surrounding states should be obtained if possible. Other options include contacting pharmacies and different providers (depending on the situation).” In this case, this patient has a history of cannabis dependency and the provider appears to be assessing compliance in a difficult pain patient. Thus, this is medically necessary and an appropriate according to the guidelines.