

<b>Case Number:</b>	CM14-0048516		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	11/07/2000
<b>Decision Date:</b>	07/29/2014	<b>UR Denial Date:</b>	03/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/28/2014

### 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 Texas. 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 62 year old male injured on 11/07/00 due to a fall. Current diagnoses included chronic pain syndrome and neck pain. The patient had withdrawn from Fioricet as of 05/05/14. The patient continued to taper methadone by one half pill per day. Clinical note dated 05/28/14 indicated the patient had associated diagnoses of depression. The patient reported significant increase in cervical spine pain following fall from tractor in 12/2013. Repeat MRI on 02/04/14 indicated the patient status post fusion at C5-6 with minimal degenerative disc disease at C4-5. The patient was treated with Cymbalta three times a day for depression and continued on current medication regimen. There were no significant objective findings provided for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Valium, 2mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Benzodiazepines Page(s): 24.

**Decision rationale:** As noted on page 24 of the Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven

and there is a risk of dependence. Most guidelines limit use to four weeks. Studies have shown that tolerance to hypnotic effects develops rapidly and tolerance to anxiolytic effects occurs within months. It has been found that long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. As such the request for Valium, 2mg #90 cannot be recommended as medically necessary at this time.

**Valium, 10mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Benzodiazepines Page(s): 24.

**Decision rationale:** As noted on page 24 of the Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to four weeks. Studies have shown that tolerance to hypnotic effects develops rapidly and tolerance to anxiolytic effects occurs within months. It has been found that long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. As such the request for Valium, 10mg #30 cannot be recommended as medically necessary at this time.

**Referral for Trial Epidural Steroid Injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Epidural steroid injections.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Epidural steroid injections (ESIs) Page(s): page(s) 46.

**Decision rationale:** As noted on page 46 of the Chronic Pain Medical Treatment Guidelines, epidural steroid injections are recommended as an option for treatment of radicular pain. Per CAMTUS a radiculopathy must be documented and objective findings on examination need to be present. Additionally, Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. Further, the location at which the injection is to occur is not specified in the request. As such, the request for Trial Epidural Steroid Injection cannot be recommended as medically necessary.

**Fiorocet, 325mg #180:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Barbiturate-containing analgesic agents (BCAs) Page(s): 23.

**Decision rationale:** As noted on page 23 of the Chronic Pain Medical Treatment Guidelines, use of Fioricet, a barbiturate-containing analgesic, is not recommended for treatment of chronic pain. Research indicates the potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy. Additionally, there is no indication in the documentation that establishes the benefits associated with the use of the medication. As such, the the request for Fiorocet, 325mg #180 cannot be established as medically necessary at this time.

**Cymbalta, 60mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cymbalta (duloxetine).

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

**Decision rationale:** As noted on page 44 of the Chronic Pain Medical Treatment Guidelines, Cymbalta is recommended as an option in first-line treatment of neuropathic pain. Duloxetine (Cymbalta) is a norepinephrine and serotonin reuptake inhibitor antidepressant (SNRIs). It has Food and Drug Administration (FDA) approval for treatment of depression, generalized anxiety disorder, and for the treatment of pain related to diabetic neuropathy, with effect found to be significant by the end of week one. The clinical documentation establishes the presence of depression successfully treated with Cymbalta. As such, the request for Cymbalta, 60mg #90 would be supported as medically necessary with as many as 3 refills. However, without subsequent evaluation of the efficacy and functional benefit, the request as written for 11 refills cannot be supported as medically necessary.

**Referral for Evaluation of Pain:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chronic Pain Disorder Medical Treatment Guidelines, State Of Colorado Department of Labor and Employment, 4/27/2007, pg.56.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines online version, Low back Complaints, page(s) Follow-up visits.

**Decision rationale:** As noted in the Low back complaints section of CA MTUS, follow-up evaluations should occur no later than one week into the acute pain period. ACOEM indicates, at the other extreme, in the stable chronic low back pain (LBP) setting, follow-up may be infrequent, such as every 6 months. There is no indication in the documentation that the patient has had a significant alteration in status, acute injury, or requires treatment out of the scope of the primary care provider. Additionally, the request did not specify the intent for referral and issues to be addressed. As such, the request for Referral for Evaluation of Pain cannot be recommended as medically necessary at this time.