

<b>Case Number:</b>	CM14-0073992		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	12/19/1996
<b>Decision Date:</b>	09/22/2014	<b>UR Denial Date:</b>	04/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/21/2014

### 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 Physical Medicine, Rehabilitation and Pain Medicine and is licensed to practice in Texas and Ohio. 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 64-year-old female who reported an injury on 12/19/1969. The mechanism of injury was not provided. On 03/24/2014, the injured worker presented with complaints of back pain, neck pain, and pain radiating into her right shoulder. Current medications included Ambien, Butrans, and Medrol packs. The diagnoses were cervical disc degeneration, cervical disc displacement, cervical spinal stenosis, cervical spondylosis, lumbar/lumbosacral disc degeneration, and lumbosacral spondylosis. Prior therapy included medications. Upon examination, the injured worker had a normal gait without a limp and could heel-walk and toe-walk strongly bilaterally. There was 5/5 motor strength in all motor groups bilaterally in the upper extremities. There was pain with cervical extension and cervical flexion. There was intact sensation in all dermatomes in the bilateral upper extremities. The provider recommended Cymbalta and Norco; the provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CYMBALTA 60 MG 90 DAYS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES Page(s): 43-44.

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

**Decision rationale:** The request for Cymbalta 60 mg for 90 days is non-certified. The California MTUS Guidelines recommend Cymbalta as an option in first line treatment for neuropathic pain. The assessment of treatment efficacy should not only include pain outcomes, but also an evaluation of function, changes in use in other analgesic medications, sleep quality and duration, and a psychological assessment. There is a lack of evidence of an objective assessment of the injured worker's pain level. Furthermore, there is a lack of documented evidence of efficacy of the injured worker's prior use of this medication. The frequency and quantity of the medication were not provided in the request as submitted. As such, the request is non-certified.

**NORCO 10/325 MG, # 90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES/OPIOIDS Page(s): 80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE Page(s): 78.

**Decision rationale:** The request for Norco 10/325 mg with a quantity of 90 is non-certified. The California MTUS Guidelines recommend the use of opioids for ongoing management of chronic pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is a lack of evidence of an objective assessment of the injured worker's pain level, functional status, evaluation for aberrant drug abuse behavior, and side effects. Additionally, the provider's request did not indicate the frequency of the medication in the request as submitted. As such, the request is non-certified.