

Case Number:	CM14-0076135		
Date Assigned:	08/22/2014	Date of Injury:	07/04/1995
Decision Date:	10/02/2014	UR Denial Date:	05/06/2014
Priority:	Standard	Application Received:	05/27/2014

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, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 53 year old female with a work injury dated 7/4/95. The diagnoses include chronic low back pain; myofascial pain syndrome/fibromyalgia; chronic left knee pain. Under consideration is a request for Oxycodone 10mg #90 and Cymbalta 90mg #90-30mg. (between 4/24/2014 and 6/30/2014) There is a 5/22/14 progress note which reveals that the patient was last time seen on April 24, 2014 for pain at the left knee, low back, neck, upper back, mid back, arm and ankle. She injured her left knee in 07/1995 and had the left knee surgery in 1996. She also developed pain at low back and other body area. However, only the left knee and low back were accepted body parts. She was diagnosed as fibromyalgia and myofascial pain. Several physicians had treated her. She took Mobie, Lorazepam 0.5mg 2 tablets at bedtime, Norco 10/325mg 6-8 tablets/day since 2000, Neurontin 300mg bid and 600mg qhs, Zanaflex 8mg tid, Ketamine cream and Cymbalta 30mg qd. She states her mood felt more depressed after coming off the Cymbalta. She had tried Nortriptyline, Ambien, Wellbutrin, Soma, Flexeril, Relafen, IV lidocaine infusion and Lidoderm patch. She had trigger point injections which gave her temporary pain relief. She took Vicodin since her injuries and switched to Norco since 2000. She had physical therapy. Fentanyl patch 25mcg/h and Cymbalta 30mg qd was started in initial visit. Her medications were adjusted multiple times. She tried Temazepam for her sleep in short time. Neurontin was gradually cut down to 200mg bid. Voltaren gel was tried for her knee pain which helped. She had panic attack and her PCP gave her BusPar 5mg qd which helped her mood and anxiety. Now, she took Fentanyl patch 25mcg/h q48h, OxylR. Neurontin 100mg qid, Cymbalta 90mg, Mobic; Colace. She stated she still felt head foggy and poor memory even with low dosage of Neurontin. She stated her low back pain and knee pain gets worse with cold weather. She walked as artist. She stated she helped city to do mural work. She did lot of paint with awkward position

which triggers her pain worse. She packed and moved her home because her husband has heart disease. She also helped to take care of the teenage with cancer. She felt more pain with cold weather. On 12/27/12 she stated she got a letter again from her insurance to cut down her pain medications. She will start animal portrait painting for the therapy dog group. She stated she could not do these activities without Fentanyl patch. She stated she was unable to tolerate the pain without medications because her left knee pain and low back pain persists. The appeal letter was sent to insurance. Neurontin was cut down to 300mg per day and gradually weaned off. Medications reduced her pain level which she can function, work and do daily activity. She stated she is off Meloxicam. She stated she feels more pain in the morning since she is off Meloxicam which she needs to take extra Oxycodone in the morning. She stated she took care of her father-in law who passed away. She took extra Oxycodone to cover her pain and she ran out it early. She states Oxycodone 10mg works better for her pain. She states neurologist prescribes her Neurontin 300mg tid which her headache went away and her other pain also feels less. Her sleep is much better. Neurontin 300mg tid was given. The urine drug test on 11/26/13 was consistent with she takes. The patient was told to cut down Cymbalta dosage since she is on Neurontin. She cut down Cymbalta to 60mg qd which she feels fine. Then she stated she feels more pain and more depressed after Cymbalta cut down to 60mg qd, especially during holiday. Cymbalta was increased to 90mg qd. On 3/25/14 she had one episode of severe right low back and buttock pain which she went to ER where CT workup is negative. She states her severe pain subsides and returned to her previous pain level. She states her low back pain and knee pain persists. Medication reduces her pain level which she can function and work. She states her function level is much higher than before. She rated her pain level as 3/10. Her mood is depressed. She is doing daily activities. Her sleep was fair. She is working part time. On physical exam the patient is alert, awake female in no acute distress. Her mood is anxious due to medication denial. Palpation of the lumbar paraspinal muscle elicits moderate tenderness bilaterally. Palpation of the knee. Elicits moderate tenderness on the left. She also has 18 out of 18 tender points in the neck, upper back, chest, knee, elbow, hip, and ankle. Her muscle strength is 5/5 in the upper and lower extremity bilaterally. Sensation was intact to pinprick in the upper and lower extremities bilaterally except hypersensitive to pinprick in the left lower extremity. Lumbar flexion is limited by 50%, extension is limited by 30%, lateral flexion and rotation limited by 40%. All range of motion made the patient discomfort, but lumbar extension is more painful. Discogenic stress maneuvers were pain provoking. The treatment plan states that the patient is very upset and anxious about insurance denial of her medication. She states she tried to cut down Cymbalta which she had bad reaction. She tried to cut down Oxycodone dosage before which she could not tolerate pain and could not function and has no quality of life. She asks other medication to control her pain. The plan includes continuing Fentanyl patch; will discontinue Oxycodone, and Cymbalta since insurance denied to cover; will continue Neurontin 300mg tid, #90 prescribed; will begin Zolof 50mg qd, #30 prescribed; and will begin MSIR.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 10mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid hyperalgesia and Opioids, criteria for use Page(s): 95-96; 76-80.

Decision rationale: Oxycodone 10mg #90 is not medically necessary per the MTUS Guidelines. The guidelines state further evaluation by a specialist with additional expertise in psychiatry, pain medicine, or addiction medicine should be considered when there is evidence of no improvement of pain with increasing doses of opioids. The documentation indicates that the patient's Oxycodone level has increased to manage her pain. She has been on long term opioids. The guidelines state that patients who receive opiate therapy sometimes develop unexpected changes in their response to opioids. This may include the development of abnormal pain (hyperalgesia), a change in pain pattern, or persistence in pain at higher levels than expected. These types of changes occur in spite of continued incremental dose increases of medication. Opioids in this case actually increase rather than decrease sensitivity to noxious stimuli. It is important therefore to note that a decrease in opioid efficacy should not always be treated by increasing the dose, but may actually require weaning. The documentation indicates that the patient had taken extra Oxycodone and ran out of pills early when she was dealing with a family death. There is also evidence that the patient's Oxycodone was changed from #150 Oxycodone 5mg daily but had to be increased due to increasing low back and knee pain. The patient takes oxycodone 10mg TID. There have been prior utilization recommendations for weaning. The documentation is concerning that opioid hyperalgesia may be occurring. Additionally with patient's history of depression and anxiety there is no evidence that the patient has had recent psychological intervention that may be contributing to her pain issues. The request for Oxycodone 10mg #90 is not medically necessary.

Cymbalta 90mg #90-30mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Selective serotonin and norepinephrine reuptake inhibitors (SNRIs): Duloxetine (Cymbalta) Page(. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: http://www.accessdata.fda.gov/drugsatfda_docs/label/2010/022516lbl.pdf

Decision rationale: Cymbalta 90mg #90-30mg is not medically necessary per the MTUS Guidelines and FDA guidelines. The FDA prescribing guidelines for Cymbalta state that there is no evidence that doses greater than 60 mg/day confers additional benefit, while some adverse reactions were observed to be dose-dependent. The documentation indicates that the patient has anxiety, depression, and Fibromyalgia which can be treated with Cymbalta, however the FDA states that doses over 60mg/day are not proven to offer more benefit. The MTUS guidelines recommend up to 60 mg once a day as an off-label option for chronic pain syndromes and also 60mg daily for Fibromyalgia. The request for Cymbalta 90mg #90-30mg is not medically necessary.