

Case Number:	CM14-0011962		
Date Assigned:	02/21/2014	Date of Injury:	05/13/2002
Decision Date:	03/27/2015	UR Denial Date:	12/30/2013
Priority:	Standard	Application Received:	01/29/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Family Practice

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 44 year old female, who sustained an industrial injury on 05/13/2002. She has reported subsequent low back and hip pain and was diagnosed with chronic postoperative pain, lumbar radiculitis, lumbago, degeneration of lumbar intervertebral disc, myalgia, depression and insomnia. Treatment to date has included oral and topical pain medication. Cymbalta, Trazadone, Ibuprofen and Kadian were chronic medications since at least 08/20/2013. In a progress note dated 12/19/2013, the injured worker complained of low back and bilateral hip pain radiating to the left lower extremity with numbness and tingling. Objective physical examination findings were notable for exquisite tenderness to palpation through the lumbar paraspinals and bilateral sciatic notches and left greater trochanter with limited lumbar range of motion. Symptoms were noted to significantly limit the injured worker's functional level and activities of daily living. A request for authorization of refills of Cymbalta, Trazadone, Ibuprofen and Kadian was made. On 12/30/2013, Utilization Review non-certified requests for Cymbalta, Trazadone, Ibuprofen and Kadian noting that the submitted documentation did not indicate any benefit with the use of the numerous medications prescribed and that several medications were prescribed for the same problem. MTUS and ODG guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cymbalta 30MG PO G AM AND 60 MG Q HS #30 for depression: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines selective serotonin reuptake inhibitors (SSRIs) Page(s): 15-16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Selective serotonin and norepinephrine reuptake inhibitors (SNRIs): Duloxetine (Cymbalta): Page(.

Decision rationale: According to the MTUS guidelines, selective serotonin and norepinephrine reuptake inhibitors (SNRIs), Duloxetine (Cymbalta) is FDA-approved for anxiety, depression, diabetic neuropathy, and fibromyalgia. Cymbalta is a first line adjuvant for chronic neuropathic pain. The injured worker is diagnosed with chronic neuropathic pain status post lumbar spine surgery. The injured worker is also diagnosed with depression. The injured worker is reporting improvement in pain and function with the current medication regimen. The request for Cymbalta 30MG PO G AM AND 60 MG Q HS #30 for depression is medically necessary.

TRAZADONE 100MG PO QHS #30 FOR INSOMNIA AND DEPRESSION: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, MENTAL ILLNESS & STRESS, TRAZADONE (DESYREL)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Mental Illness & Stress Chapter:Trazodone (Desyrel)

Decision rationale: According to the Official Disability Guidelines, Trazodone (Desyrel) is recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. This medication is being requested for insomnia and depression associated with chronic pain syndrome. The injured worker is reporting improvement with the current medication regimen. The request for Trazadone 100 mg p.o. qhs for insomnia and depression is medically necessary.

IBUPROFEN 800MG PO THREE TIMES A DAY #90 FOR INFLAMMATION:

Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines IBUPROFEN Page(s): 72.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications, Ibuprofen Page(s): 21, 71.

Decision rationale: According to the MTUS guidelines, anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. The injured worker is followed for chronic pain and is reporting decreased pain and improvement in function with the current medication regimen. The request

for Ibuprofen as a first line anti-inflammatory agent to address the inflammatory component in this injured worker's chronic pain syndrome is supported. The request for Ibuprofen 800 mg p.o. three times a day #90 for inflammation is medically necessary.

KADIAN 20MG PO TWICE DAILY #60 FOR PAIN: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MORPHINE SULFATE Page(s): 93.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: The injured worker is followed for chronic post operative pain. She is reporting improvement in pain and function with the current medication regimen. There is also no evidence of abuse or diversion with the current opioid medication regiment. The MTUS guidelines state that opioids may be continued if there has been improvement in pain and function. Given the improvement in pain and function, given that there is no evidence of abuse, and given the low morphine equivalent dosage, the request for Kadian is supported. The request for Kadian 20 mg p.o. twice daily #60 for pain is medically necessary.