

Case Number:	CM14-0196451		
Date Assigned:	12/04/2014	Date of Injury:	02/12/1996
Decision Date:	03/16/2015	UR Denial Date:	11/13/2014
Priority:	Standard	Application Received:	11/24/2014

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: Physical Medicine & Rehabilitation, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a female who sustained a work related injury on 2/12/1996. The mechanism of injury has not been provided with the clinical documentation submitted for review. Per the periodic report and request for authorization dated 10/29/2014 the injured worker reported limited activities of daily living due to chronic pain but are stable with her current medications. Objective physical examination revealed cervical thoracic junction kyphosis measured at 40 degrees. The left wrist has limited range of motion. There is severe tenderness to the thoracic spine with significant muscle spasm and breathing limited on the left. There was tremor in the left upper extremity. Diagnoses include complex regional pain syndrome with degenerative disc disease, thoracic ankyloses and kyphosis, severe left shoulder ankyloses. The plan of care includes medication management and follow-up care. Work Status is not provided. On 11/13/2014, Utilization Review non-certified a prescription for Gabitril 4mg #60 based on guideline recommendations for first line medications and Duloxetine 60mg #30 based on lack of documented functional improvement. The ACOEM Guidelines; Goodman and Gilman's The Pharmacological Basis of Therapeutics, 12th ed. McGraw Hill, 2010.; Physician's Desk Reference, 68th ed. (www.RxList.com); ODG Worker's Compensation Drug Formulary, (www.odg-twc.com/odgtwc/formulary.htm); drugs.com; Epocrates online (www.online>epocrates.com); Monthly Prescribing Reference (www.empr.com); Opioid Dose Calculator - AMDD Agency Medical Directors' Group Dose Calculator (www.agencymeddirectors.wa.gov) were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

2 Gabitril 4mg 2 tabs nightly and hour prior to sleep #60: 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 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 16-21 of 127.

Decision rationale: Regarding request for the anti-epileptic drug in dispute, the Chronic Pain Medical Treatment Guidelines state that antiepileptic drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is documentation in a progress note from 10/29/2014 that there is >50% reduction of neuralgia type pain due to Gabitril. The provider charts the patient's functional status and notes there has been some improvement in ADLs on this regimen. It should be further noted that the MTUS does not specify which medications are considered 1st line or 2nd line as suggested by the utilization reviewer. Therefore, the currently requested medication is medically necessary.

Duloxetine 60mg 1 cap 3 hours prior to sleep #30: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009). Page(s): 50, 61, 159.

Decision rationale: Regarding the request for Cymbalta, Chronic Pain Medical Treatment Guidelines states that Cymbalta is an SNRI antidepressant that has been shown to be effective in relieving neuropathic pain of different etiologies. In this patient, there is documentation of clinical efficacy of Cymbalta in reducing pain. In fact, a progress note from October 29, 2014 indicates that the Cymbalta is "calming" the neuralgia symptoms. As this treatment option is recommended by the California Medical Treatment Utilization Schedule, it is medically necessary.