

Case Number:	CM14-0208192		
Date Assigned:	12/19/2014	Date of Injury:	10/08/1992
Decision Date:	02/11/2015	UR Denial Date:	11/13/2014
Priority:	Standard	Application Received:	12/11/2014

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 Internal Medicine and is licensed to practice in California. 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 (IW) is a 64-year-old woman with a date of injury of October 8, 1992. The mechanism of injury was not documented in the medical record. The injured worker's working diagnoses are chronic neck pain; and history of cervical spine fusion. The IW had cervical fusion at C5-C7 on April 22, 1999. The most recent report available is from the Neurologist dated March 11, 2014. There was no letterhead or signature signed or printed at the beginning and end of the progress note. That report did not mention this medication nor is there a diagnosis of depression. There was a past medical history of anxiety. There was no indicated the IW had neuropathic pain. Subjective complaints are limited to neck pain, and feelings of tingling and needles at her scalp. At the end of the documentation, there is an entry by the provider stating, "Patient was seen at the psyche department and was prescribed Effexor. I advised her to pick up her medication and start taking it". There was no documentation in the medical record regarding Cymbalta (Duloxetine). The current request is for Duloxetine HCL 30mg #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Duloxetine HCL 30mg Quantity: 30 for 30 day supply: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43-44. Decision based on Non-MTUS Citation <http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=2f7d4d67-10c14bf4-a/12-c185fbad64ba>

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Duloxetine Page(s): 42. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Pain Section, Duloxetine

Decision rationale: Pursuant to the MTUS Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Duloxetine HCL 30 mg #30/30 day supply is not medically necessary. Duloxetine is recommended as a first-line treatment for neuropathic pain. It is FDA approved for treatment of depression, generalized anxiety disorder and treatment of pain related to diabetic neuropathy with affect to be significant by end of week one. In this case, the injured worker's working diagnoses are chronic neck pain; and history of cervical spine fusion. A neurology note dated March 11, 2014 is present in the medical record. There is no letterhead and no signature, signed or printed, at the beginning or end of the progress note. Physical examination does not show any neuropathic signs and subjective complaints are limited to constant neck pain with complaint of headache and feeling of tingling and needles at her scalp. There are no neuropathic symptoms involving the extremities. At the end of the report in section #24 the documentation states "patient was seen at the psych department and was prescribed Effexor. I advise her to pick up her medication and start taking it." There is no documentation in the medical record indicating Duloxetine is recommended. There is no documentation with clinical indication of clinical rationale for Duloxetine. Consequently, absent the appropriate clinical indications/rationale and documentation to support the use of Duloxetine, the request for Duloxetine HCl #30/30 day supply is not medically necessary.