

Case Number:	CM15-0108006		
Date Assigned:	06/12/2015	Date of Injury:	01/04/2001
Decision Date:	07/21/2015	UR Denial Date:	05/16/2015
Priority:	Standard	Application Received:	06/04/2015

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: North Carolina

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 57-year-old male, who sustained an industrial injury on 1/04/2001. He reported feeling a pop in his back while lifting a heavy object. The injured worker was diagnosed as having post lumbar laminectomy syndrome, lumbar radiculopathy, lumbar facet syndrome, and knee pain. Treatment to date has included diagnostics, pain management, and multiple spinal surgeries, left knee surgery, physical therapy, and medications. Currently, the injured worker complains of low back and left knee pain. Pain was rated 7/10 with medications and 10/10 without. His quality of sleep was poor and he denied any other therapies for pain relief. His activity level was decreased. He was upset regarding being tapered off Soma and stated that Zanaflex was not helping with spasms. Aquatherpay and psychotherapy were approved but he did not feel this was of any benefit. Current medications included Duloxetine, Famotidine, Gabapentin, Ibuprofen, Pennsaid solution, Hydrocodone/Acetaminophen, DHEA, and Zanaflex. The use of Norco and Cymbalta was noted for greater than two years. Urine toxicology (6/27/2014) was inconsistent with expected results. A review of symptoms was positive for mood swings. Exam of the lumbar spine noted restricted range of motion, positive facet loading bilaterally, and positive left straight leg raise. Exam of the left knee noted crepitus with active movement, tenderness to palpation, and trace effusion. Motor strength was 5/5, except extensor hallucis longus 4/5 on the left. Urine toxicology 3/2015 was documented as consistent with prescribed medications. His work status was total temporary disability. The treatment plan included continued slow tapering of some medications. He deferred physical therapy due to minimal previous benefit and was encouraged to continue home exercise program. He was to continue transcutaneous electrical nerve stimulation unit. Continued medications were recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone Acetaminophen 10/325 mg #90 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): s 76-84.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs (Passik, 2000). (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to nonopioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids; (a) If the patient has returned to work, (b) If the patient has improved functioning and pain (Washington, 2002), (Colorado, 2002), (Ontario, 2000), (VA/DoD, 2003), (Maddox-AAPM/APS, 1997), (Wisconsin, 2004), (Warfield, 2004). The long-term use of this medication class is not recommended per the California MTUS unless there is documented evidence of benefit with measurable outcome measures and improvement in function. There is documented significant improvement in VAS scores for significant periods of time. There are no objective measurements of improvement in function. Therefore all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.

Duloxetine HCL DR 60 mg #30 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cymbalta Page(s): 15.

Decision rationale: The California MTUS section on Cymbalta states: Duloxetine (Cymbalta): FDA-approved for anxiety, depression, diabetic neuropathy, and fibromyalgia. Used off-label for neuropathic pain and radiculopathy, Duloxetine is recommended as a first-line option for diabetic neuropathy (Dworkin, 2007). No high quality evidence is reported to support the use of duloxetine for lumbar radiculopathy (Dworkin, 2007). More studies are needed to determine the efficacy of duloxetine for other types of neuropathic pain. The patient does not have diabetic neuropathy or fibromyalgia and therefore the request is not medically necessary.