

Case Number:	CM15-0130180		
Date Assigned:	07/16/2015	Date of Injury:	11/10/2009
Decision Date:	09/10/2015	UR Denial Date:	06/09/2015
Priority:	Standard	Application Received:	07/06/2015

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: Arizona, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 63 year old female injured worker suffered an industrial injury on 11/10/2009. The diagnoses included lumbar fusion and revision, opioid dependence lumbar moderate to severe neuroforaminal stenosis, lumbosacral disc degeneration, lumbar arachnoiditis and chronic pain. The diagnostics included thoracic and lumbar x-rays and lumbar magnetic resonance imaging. . The treatments included medications and physical therapy. On 4/30/2015 the treating provided reported the urine drug screen was consistent. The injured worker complained of ongoing pain in the low back with radiation to the legs. She described the pain as electric shocks running down the legs. She complained of numbness and tingling in the arms and legs when lying down. She reported pain relief when taking medications and with therapy. On exam the lumbar spine had painful range of motion. She was started on Cymbalta during this visit. It was not clear the if injured worker had returned to work. The requested treatments included Cymbalta 60 mg Qty 30 with 2 refills, Norco 10/325 mg Qty 150, Tizanidine 4 mg Qty 120 with 2 refills, Trazodone 100 mg Qty 60 with 2 refills and Gabapentin 800 mg Qty 120 with 2 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cymbalta 60 mg Qty 30 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressant for chronic pain Page(s): 14-16.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines for antidepressants for chronic pain recommend as a first line option for neuropathic pain and as a possibility for non-neuropathic pain. Tricyclic medications are generally considered a first line agent unless they are ineffective, poorly tolerated or contraindicated. Assessment of treatment efficacy should include not only pain outcomes but also an evaluation of function, changes in use of other analgesic medications, sleep quality and duration and psychological assessment. The documentation provided indicated Cymbalta was being started for chronic pain but no trial of a first-line agent was noted. Therefore Cymbalta was not medically necessary.

Norco 10/325 mg Qty 150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-94.

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

Decision rationale: MTUS discourages long term usage unless there is evidence of "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." The documentation needs to contain assessments of analgesia, activities of daily living, adverse effects and aberrant drug taking behavior. The documentation provided did not include a comprehensive pain assessment and evaluation or evidence of functional improvement specifically for this medication. Therefore Norco was not medically necessary.

Tizanidine 4 mg Qty 120 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-65.

Decision rationale: MTUS Chronic pain Medical Treatment Guidelines recommended oral muscle relaxants for a short course 2 to 3 weeks for acute neck and back conditions or for acute exacerbations and any repeated use should be contingent on evidence of specific prior benefit. Efficacy diminished overtime and prolonged use may lead to dependence. The preference is for

non-sedating muscle relaxants. There are also indications for post-operative use. The documentation provided did not show evidence of an acute exacerbation or evidence of and acute neck or back condition. The medication had been utilized for at least 6 months without evidence of prior benefit. Therefore Tizanidine was not medically necessary.

Trazodone 100 mg Qty 60 with 2 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain - Trazodone (Desryl), antidepressants for chronic pain.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Insomnia treatment.

Decision rationale: MTUS was silent on this medication. ODG recommended Trazodone as an option for insomnia only for patient with potentially coexisting mild psychiatric symptoms such as depression or anxiety. The documentation provided did not include a diagnosis or symptoms of sleep dysfunction. The prescription was written to be taken at time of sleep which indicated it was for sleep. There was no coexisting psychiatric condition that is indicated for this medication. There was no evidence of any clinical benefit. Therefore Trazodone was not medically necessary.

Gabapentin 800 mg Qty 120 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti epilepsy drugs Page(s): 16-19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines AED (Antiepileptic drug) Page(s): 16-22.

Decision rationale: The MTUS Chronic pain Medical Treatment Guidelines recommend antiepileptic drugs (AED) for neuropathic pain for post herpetic neuralgia, spinal cord injury and painful poly neuropathy. The documentation provided did not include any of the above indication for usage. There was no evidence of functional improvement or efficacy of this medication. Therefore Gabapentin was not medically necessary.