

Case Number:	CM15-0131187		
Date Assigned:	07/17/2015	Date of Injury:	10/05/1998
Decision Date:	08/17/2015	UR Denial Date:	06/25/2015
Priority:	Standard	Application Received:	07/07/2015

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: California

Certification(s)/Specialty: Emergency 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 injured worker is a 62-year-old male who sustained an industrial injury on 10/5/1998 resulting in radiating neck pain, back pain, knee pain, and, arm and wrist pain. He is diagnosed with lumbosacral radiculopathy and disc protrusion; disc desiccation at L5-S1; musculoligamentous lumbosacral spasm; knee osteoarthritis; leg joint pain; multiple left shoulder and knee surgeries; and, right and left carpal tunnel release; and, rheumatoid arthritis. Documented treatment has included multiple surgeries to shoulder and knee, bilateral knee braces, oral and transdermal medication, physical therapy and joint injections. Effectiveness of treatments is not noted. The injured worker continues to present with cervical pain which radiates to bilateral shoulders, wrists, and hands; pain in the thoracic and lumbar spine and bilateral knees; and, frequent falls. The requesting provider is a psychiatrist and it is not noted if the medications are for chronic pain or for depression/anxiety. The treating physician's plan of care includes Duloxetine, Trazodone, and Gabapentin. He is permanently disabled.

IMR ISSUES, DECISIONS AND RATIONALES

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

Duloxetine 60 mg Qty unspecified (retrospective DOS 6/8/15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants for chronic pain Page(s): 13-15.

Decision rationale: Cymbalta/Duloxetine is a type of SNRI anti-depressant medication. As per MTUS Chronic pain guidelines, anti-depressants may be considered for neuropathic pain. It is unclear if patient is on this medication for depression or pain. There is no documented objective improvement in pain or function although patient has been noted to be stable on current regiment. Note by psychiatrist does not mention any benefit from medication related to improvement in pain or mental status. It merely notes various social issues and complaints the patient has related to other problems. This is also an incomplete prescription with no total number of tablets or frequency provided. This medication may be beneficial but the documentation fails to support use of Cymbalta and the incomplete prescription request invalidates the request. Cymbalta is not medically necessary.

Trazodone 100 mg Qty unspecified (retrospective DOS 6/8/15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants for chronic pain Page(s): 13-15.

Decision rationale: Trazodone is a type of anti-depressant medication that is sometimes used for sleep. As per MTUS Chronic pain guidelines, anti-depressants may be considered for neuropathic pain. However, it is a 2nd line medication. There is no documentation of prior attempts at other 1st line anti-depressants. It is unclear if patient is on this medication for depression or pain. There is no documented objective improvement in pain or function although patient has been noted to be stable on current regiment. Note by psychiatrist does not mention any benefit from medication related to improvement in pain or mental status. It merely notes various social issues and complaints the patient has related to other problems. This is also an incomplete prescription with no total number of tablets or frequency provided. This medication may be beneficial but the documentation fails to support use of Trazodone and the incomplete prescription request invalidates the request. The request for Trazodone is not medically necessary.

Gabapentin 300 mg Qty unspecified (retrospective DOS 6/8/15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti epilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 18-19.

Decision rationale: Gabapentin (Neurontin) is an anti-epileptic drug with efficacy in neuropathic pain. It is most effective in polyneuropathic pain. Pt has been on this medication chronically and there is no documentation of actual benefit. There is no documentation of any objective improvement with only some vague reports of subjective improvement. This is also an incomplete prescription with no total number of tablets or frequency provided. Gabapentin is not medically necessary.