

Case Number:	CM15-0188451		
Date Assigned:	09/30/2015	Date of Injury:	04/15/2011
Decision Date:	11/10/2015	UR Denial Date:	09/24/2015
Priority:	Standard	Application Received:	09/24/2015

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: Texas, Florida, California

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 injured worker is a 51 year old male, who sustained an industrial injury on 4-15-2011. The injured worker is being treated for extremity pain, hand pain, low back pain and cervical pain. Treatment to date has included surgical intervention (left and right carpal tunnel releases, 2011), diagnostics, physical therapy, acupuncture, chiropractic, biofeedback therapy, psychotherapy, one lumbar epidural steroid injection, medications and work restrictions. Per the Primary Treating Physician's Progress Report dated 9-11-2015, the injured worker presented for neck pain and bilateral upper extremity pain. He reported that the pain level has decreased since the last visit. He rates his pain level with medications as 3 out of 10 and without medications and 7 out of 10. His activity level has increased. Medications included Cymbalta, Lyrica, Trazodone, Norco and Atorvastatin and Lisinopril. Objective findings included hypertonicity, spasm, tenderness and a tight muscle band on both sides of the cervical spine. Range of motion of the lumbar spine was restricted. There was tenderness to the sub deltoid bursa of the bilateral shoulders. This was the only pertinent medical record submitted. There is no documentation of improvement in symptoms, increase in activities of daily living or decrease in pain level with the current treatment. The notes from the provider do not document efficacy of the prescribed medications. Work status was permanent and stationary. The plan of care included medications and authorization was requested on 9-16-2015 for Cymbalta 60mg #30, Trazodone 50mg #15 and Lyrica 75mg #120. On 9-24-2015, Utilization Review non-certified the request for Cymbalta, Trazodone and Lyrica.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cymbalta 80mg capsule QTY 30 with one refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, under Antidepressants.

Decision rationale: The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. Regarding anti-depressants to treat a major depressive disorder, the ODG notes: Recommended for initial treatment of presentations of Major Depressive Disorder (MDD) that is moderate, severe, or psychotic, unless electroconvulsive therapy is part of the treatment plan. Not recommended for mild symptoms. In this case, it is not clear what objective benefit has been achieved out of the anti-depressant usage, how the activities of daily living have improved, and what other benefits have been. It is not clear if this claimant has a major depressive disorder as defined in DSM-IV. If used for pain, it is not clear what objective, functional benefit has been achieved. The request is appropriately non-certified, therefore is not medically necessary.

Trazodone 50mg tablet QTY 15 with one refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Stress/Mental section, Trazodone.

Decision rationale: Regarding Trazodone, the MTUS is silent. The ODG notes, in the Stress/Mental section: Recommended as an option for insomnia, only for patients with potentially co-existing mild psychiatric symptoms such as depression or anxiety. See also Insomnia treatment, where it says there is limited evidence to support its use for insomnia, but it may be an option in patients with coexisting depression. Trazodone has also been used for fibromyalgia. Although approved to treat depression, the American Psychiatric Association notes that it is not typically used for major depressive disorder. The AHRQ Comparative Effectiveness Research on insomnia concludes that trazodone is equal to zolpidem. (AHRQ, 2008) However, evidence for the off-label use of trazodone for treatment of insomnia is weak. The current recommendation is to utilize a combined pharmacologic and psychological and behavior treatment when primary insomnia is diagnosed. There has been no dose-finding study performed to assess the dose of trazodone for insomnia in non-depressed patients. Other pharmacologic therapies should be recommended for primary insomnia before considering trazodone, especially if the insomnia is not accompanied by co-morbid depression or recurrent treatment failure. In this case, the evidence support either for primary psychiatric disorder usage, or as an option for a primary insomnia with co-existing psychiatric symptoms, is poor. The request is appropriately non-certified, therefore is not medically necessary.

Lyrica 75mg capsule QTY 120 with one refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Anti-epilepsy drugs (AEDs).

Decision rationale: Chronic Pain Medical Treatment Guidelines 8 C.C.R MTUS (Effective July 18, 2009) Page 16 of 127. The MTUS notes that these medicines are recommended for neuropathic pain (pain due to nerve damage). (Gilron, 2006) (Wolfe, 2004) (Washington, 2005) (ICSI, 2005) (Wiffen-Cochrane, 2005) (Attal, 2006) (Wiffen-Cochrane, 2007) (Gilron, 2007) (ICSI, 2007) (Finnerup, 2007) The MTUS further notes that most randomized controlled trials (RCTs) for the use of this class of medication for neuropathic pain have been directed at post-herpetic neuralgia and painful polyneuropathy (with diabetic polyneuropathy being the most common example). I did not see that this claimant had these conditions for which the medicine is effective. The request was appropriately non-certified under MTUS criteria, therefore is not medically necessary.