

<b>Case Number:</b>	CM15-0189550		
<b>Date Assigned:</b>	10/01/2015	<b>Date of Injury:</b>	12/01/2010
<b>Decision Date:</b>	12/09/2015	<b>UR Denial Date:</b>	08/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2015

### 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: Georgia

Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 49 year old male who sustained an industrial injury on 12/01/2010. A review of the medical records indicated that the injured worker is undergoing treatment for the left shoulder and displacement of cervical intervertebral disc without myelopathy. The injured worker is status post two left shoulder surgeries (no dates or procedures documented). According to the treating physician's progress report on 08-11-2015, the injured worker continues to experience left shoulder pain with swelling, tenderness and throbbing rated at 7-8 out of 10 on the pain scale and cervical pain radiating bilaterally associated with weakness, numbness and tingling rated at 7-8 out of 10 on the pain scale. The injured worker reported 50% improvement in pain with medications. The injured worker reported turning his neck worsens the condition. Examination performed on 08-06-2015 demonstrated motor strength for all groups tested in the left shoulder, arm, fingers and thumb at 4 plus out of 5 and decreased range of motion with pain in all direction. Medial nerve compression test reproduced numbness and tingling on the left and Tinel's was abnormal. The neck examination demonstrated pain to palpation over C2 through C5 facet capsules on the left with secondary myofascial pain with triggering and ropey fibrotic banding. There was pain with rotational extension, positive Spurling's and positive maximal foraminal compression testing. The C6 and C7 dermatome noted decreased light touch sensation on the left. Left biceps and brachioradialis reflexes were 2 out of 4. A positive Tinel's at the wrist and elbow reproduced the radiating pain. Prior treatments have included diagnostic testing, surgery, physical therapy, acupuncture therapy, chiropractic therapy, home exercise program and medications. Current medications were listed as Vicodin,

Duragesic patch, Neurontin, Cymbalta and Zanaflex. Urine drug screening tests were reported by the physician in the progress reports as consistent with prescribed medications. Treatment plan consists of the current request for Cymbalta 60mg, 3 Caps once daily #90, Neurontin 300mg, 1-2 Caps 3 times a day #180, Duragesic Patch 25mcg per hour, 1 patch every 3 days #10 and Zanaflex 2mg, one tab twice a day #60. On 08-26-2015 the Utilization Review determined the request for Zanaflex 2mg #60 and Cymbalta 60mg #90 was not medically necessary. The Utilization Review modified the requests for Duragesic Patch 25mcg per hour, 1 patch every 3 days #10 to Duragesic Patch 25mcg per hour #5 and Neurontin 300mg, 1-2 Caps 3 times a day #180 to Neurontin 300mg, #90, on 08-26-2015.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Cymbalta 60mg 3 Caps once daily #90: 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): Antidepressants for chronic pain.

**Decision rationale:** Cymbalta 60 mg 3 caps once daily #90 is not medically necessary. Per CA MTUS, Duloxetine (Cymbalta) is 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 medical records do not appropriately address whether the claimant has depression associated with chronic pain through psychological evaluation. Additionally there was no documentation that the enrollee failed Tricyclics which is recommended by CA MTUS as first line therapy. Therefore, the requested medication is not medically necessary.

#### **Neurontin 300mg 1-2 Caps Tid #180: Overturned**

**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:** Neurontin 300mg 1-2 caps TID #180 is medically necessary. Ca MTUS 17-19 Recommended for neuropathic pain (pain due to nerve damage). There is a lack of expert consensus on the treatment of neuropathic pain in general due to heterogeneous etiologies, symptoms, physical signs and mechanisms. 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). There

are few RCTs directed at central pain and none for painful radiculopathy. (Attal, 2006) The choice of specific agents reviewed below will depend on the balance between effectiveness and adverse reactions. Additionally, Per MTUS One recommendation for an adequate trial with gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. (Dworkin, 2003) The patient should be asked at each visit as to whether there has been a change in pain or function. The claimant did report 50% improved function. Additionally, Neurontin is recommended for neuropathic pain. The claimant was diagnosed with Neuropathic pain; therefore, the requested medication is medically necessary.

**Duragesic Patch 25mcg/Hr 1 Patch Q 3 Days #10: 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): Duragesic (fentanyl transdermal system).

**Decision rationale:** Duragesic Patch 25mcg/Hr 1 Patch Q 3 Days #10 is not medically necessary. Per MTUS Page 79 of MTUS guidelines states that weaning of opioids are recommended if (a) there are no overall improvement in function, unless there are extenuating circumstances (b) continuing pain with evidence of intolerable adverse effects (c) decrease in functioning (d) resolution of pain (e) if serious non-adherence is occurring (f) the patient requests discontinuing. The claimant's medical records did not document that there was an overall improvement in function or a return to work with previous opioid therapy. The claimant has long-term use with this medication and there was a lack of improved function with this opioid; therefore the requested medication is not medically necessary. It is more appropriate to wean the claimant of this medication to avoid side effects of withdrawal.

**Zanaflex 2mg 1 Tab Bid #60: 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): Muscle relaxants (for pain).

**Decision rationale:** Zanaflex 2mg 1 tab BID #60 is not medically necessary. Tizanidine (Zanaflex, generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. (Malanga, 2008) Eight studies have demonstrated efficacy for low back pain. (Chou, 2007) One study (conducted only in females) demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain. (Malanga, 2002) May also provide benefit as an adjunct treatment for fibromyalgia. (ICSI, 2007). The recommended dosing is 4mg with a max dose of 36 mg per day. The medical records indicate that the Zanaflex was prescribed for back pain. MTUS recommends short-term use for myofascial pain or fibromyalgia; therefore, the claim is not medically necessary.