

Case Number:	CM15-0027505		
Date Assigned:	02/19/2015	Date of Injury:	05/03/2013
Decision Date:	03/31/2015	UR Denial Date:	02/04/2015
Priority:	Standard	Application Received:	02/13/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

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 60 year old female, who sustained an industrial injury on 5/3/2013. She has reported bilateral shoulder, left elbow, and low back and bilateral knee pain. The diagnoses have included internal derangement right knee, status post arthroscopy 6/27/14, lumbosacral sprain, and left elbow strain. Treatment to date has included medication therapy, physical therapy, and joint injection. Currently, the IW complains of persistent low back, left elbow and knee pain. Physical examination from 12/17/14 documented tenderness and decreased Range of Motion (ROM) of lumbar spine, and tenderness to right knee and left elbow. The plan of care included acupuncture and pain management. On 2/4/2015 Utilization Review non- certified Cymbalta 60mg #30 and Lidocaine Patches 5% (up to three (3) patches over problem areas, twelve hours on / twelve hours off), noting the documentation did not support that the guidelines had been met. The MTUS Guidelines were cited. On 2/13/2015, the injured worker submitted an application for IMR for review of Cymbalta 60mg #30 and Lidocaine Patches 5% (up to three (3) patches over problem areas, twelve hours on / twelve hours off).

IMR ISSUES, DECISIONS AND RATIONALES

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

Cymbalta 60 mg #30: 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 Guidelines Pain Interventions and Treatments, Page(s): page 15-16.

Decision rationale: MTUS state regarding antidepressants for pain, Recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. (Feuerstein, 1997) (Perrot, 2006) Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. The treating physician does not indicate failure of first-line agents and does not indicate how a first line agent is ineffective, poorly tolerated, or contraindicated. MTUS states regarding Cymbalta: Selective serotonin and norepinephrine reuptake inhibitors (SNRIs): 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. Side effects: CNS: dizziness, fatigue, somnolence, drowsiness, anxiety (3% vs.2% for placebo), insomnia (8-13% vs. 6-7% for placebo). GI: nausea and vomiting (5-30%), weight loss (2%). Trial period: Some relief may occur in first two weeks; full benefit may not occur until six weeks. Withdrawal effects can be severe. Abrupt discontinuation should be avoided and tapering is recommended before discontinuation. Medical records do not substantiate anxiety, depression, diabetic neuropathy, and/or fibromyalgia, which are the only FDA indicated uses of Cymbalta. As such, the request for Cymbalta 60mg #30 is not medically necessary.

Lidocaine Patches 5% (up to 3 patches over problem areas, 12 hrs on/ 12 hrs off): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Patches Page(s): 56-57. Decision based on Non-MTUS Citation Pain, Topical analgesics UpToDate.com, Lidocaine (topical)

Decision rationale: Chronic Pain Medical Treatment Guidelines state: Lidoderm is the brand name for a lidocaine patch produced by [REDACTED]. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. For more information and references, see Topical analgesics.ODG further details: Criteria for use of Lidoderm patches:(a) Recommended for a

trial if there is evidence of localized pain that is consistent with a neuropathic etiology.(b) There should be evidence of a trial of first-line neuropathy medications (tri-cyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica).(c) This medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points.(d) An attempt to determine a neuropathic component of pain should be made if the plan is to apply this medication to areas of pain that are generally secondary to non-neuropathic mechanisms (such as the knee or isolated axial low back pain). One recognized method of testing is the use of the Neuropathic Pain Scale.(e) The area for treatment should be designated as well as number of planned patches and duration for use (number of hours per day).(f) A Trial of patch treatment is recommended for a short-term period (no more than four weeks).(g) It is generally recommended that no other medication changes be made during the trial period.(h) Outcomes should be reported at the end of the trial including improvements in pain and function, and decrease in the use of other medications. If improvements cannot be determined, the medication should be discontinued.(i) Continued outcomes should be intermittently measured and if improvement does not continue, lidocaine patches should be discontinued. Medical documents provided do not indicate that the use would be for post-herpetic neuralgia. Additionally, treatment notes did not detail other first-line therapy used and what the clinical outcomes resulted. As such, the request for Lidocaine Patches 5% (up to 3 patches over problem areas, 12 hrs on/ 12 hrs off) is not medically necessary.