

<b>Case Number:</b>	CM15-0211812		
<b>Date Assigned:</b>	10/30/2015	<b>Date of Injury:</b>	10/04/2001
<b>Decision Date:</b>	12/11/2015	<b>UR Denial Date:</b>	10/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/27/2015

### 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, California

Certification(s)/Specialty: Family Practice

### 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 57 year old male, who sustained an industrial injury on 10-4-2001. Diagnoses include epidural fibrosis with occlusion of nerve root improvement status post epidural injection, bladder tear and impotence status post improper foley placement, radicular pain, insomnia secondary to pain, chronic pain syndrome, and constipation from opioid use, status post lumbar fusion in 2007. Treatments to date include activity modification, medication therapy, cognitive behavioral therapy, acupuncture treatments, and epidural steroid injection. On 10-8-15, he some improvement in low back pain status post lumbar epidural approximately three months prior with ability to reduce narcotics for the previous two months. Pain was noted to be returning with radiation to bilateral lower extremities. The records documented Nucynta, MS Contin, and Cymbalta were prescribed for at least six months. Medications were noted to improve mobility function and quality of life. MSER and Nucynta was noted to decrease pain and gabapentin was noted to be most effective. Lunesta was highly effective for pain related insomnia noting sleep improved to 6-8 hours per night, and waking 1-2 hours without. Pain was rated 9 out of 10 VAS without medication and 4-6 out of 10 VAS with medication. The physical examination documented lumbar tenderness with muscle spasms noted, decreased motor strength in lower extremities, and decreased sensation in left greater than right lower extremity. The plan of care included ongoing medication therapy. The appeal requested authorization for Cymbalta 60mg #30 and Lunesta 3mg #30. The Utilization Review dated 10-16-15, denied the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cymbalta 60mg #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) mental chapter and pg 16.

**Decision rationale:** Cymbalta is an SNRI antidepressant. Antidepressants are an option, but there are no specific medications that have been proven in high quality studies to be efficacious for treatment of lumbosacral radiculopathy. SSRIs have not been shown to be effective for low back pain (there was not a significant difference between SSRIs and placebo) and SNRIs have not been evaluated for this condition. The claimant had been on Cymbalta for several months. Cymbalta may be used for depression as it was mentioned it had been. However, response to medication was not provided. The continued use is not justified and is not medically necessary.

**Lunesta 3mg #30: 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 and pg 64.

**Decision rationale:** The MTUS guidelines do not comment on insomnia. According to the ODG guidelines, recommend that treatment be based on the etiology, with the medications. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. In this case, the claimant had used Ambien in the past. Pain rather than a primary sleep disturbance affected sleep. Failure of behavioral interventions was not noted. Continued use of Lunesta is not medically necessary.