

<b>Case Number:</b>	CM15-0031956		
<b>Date Assigned:</b>	02/25/2015	<b>Date of Injury:</b>	09/19/2007
<b>Decision Date:</b>	04/08/2015	<b>UR Denial Date:</b>	02/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/20/2015

### 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: Physical Medicine & Rehabilitation

### 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 female who reported injury on 09/19/2007. The mechanism of injury was not provided. The documentation indicated the injured worker had utilized Naprosyn, Cymbalta, Amrix and Lyrica since at least 08/2014. There was a Request for Authorization submitted for review dated 01/26/2015. The documentation of 01/13/2015 revealed the injured worker had undergone multiple upper extremity surgeries including bilateral wrists, elbows and right shoulder. The injured worker underwent an EMG and NCS of the bilateral upper extremities on 04/11/2014 that was read as normal. The injured worker indicated her pain without medications was 10/10 and with medications was 5/10. The documentation indicated the medications kept the injured worker functional allowing for increased mobility and tolerance of activities of daily living and home exercises. There were no side effects. The medications included hydrocodone/acetaminophen 2.5/325 mg, Naprosyn 500 mg, Cymbalta 30 mg, Amrix 15 mg, Lyrica 75 mg, Lidoderm 5% patches and Voltaren gel. Additionally, the injured worker was utilizing cyclobenzaprine 7.5 mg and it was noted to be on hold. The physical examination revealed the injured worker had tenderness to palpation in the cervical, thoracic and lumbar spine. The injured worker had a positive straight leg raise bilaterally. The treatment plan included Cymbalta 30 mg 1 by mouth daily, Lyrica 75 mg 1 by mouth 3 times a day, Amrix 15 mg 1 by mouth daily as needed spasms, and Naprosyn 500 mg tablets 1 by mouth twice a day as needed inflammation. The diagnoses included myofascial pain syndrome, fibromyalgia, pain in joint upper arm and shoulder, carpal tunnel syndrome, interstitial myositis and unspecified drug dependence unspecified abuse. The diagnostic studies were not provided.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Cymbalta 30 mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines antidepressants Page(s): 13.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines recommend antidepressants as a first line medication for treatment of neuropathic pain and they are recommended especially if pain is accompanied by insomnia, anxiety, or depression. There should be documentation of an objective decrease in pain and objective functional improvement to include an assessment in the changes in the use of other analgesic medications, sleep quality and duration and psychological assessments. The clinical documentation submitted for review failed to provide documentation of an objective decrease in pain and documentation of the changes in the use of other analgesic medications, sleep quality, duration and psychological assessments. The request as submitted failed to indicate the frequency and the quantity of medication being requested. Given the above, the request for Cymbalta 30 mg is not medically necessary.

**Lyrica 75 mg X one month supply:** 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-epileptic Drugs Page(s): 16.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines recommend anti-epilepsy medications as a first line medication for treatment of neuropathic pain. There should be documentation of an objective decrease in pain of at least 30 % - 50% and objective functional improvement. The clinical documentation submitted for review failed to provide documentation of 30% to 50% decrease in pain and objective functional improvement. The request as submitted failed to indicate the frequency for the requested medication as well as the quantity of medication being requested. Given the above, the request for Lyrica 75 mg x1 month supply is not medically necessary.

**Amrix 15 mg:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration of time and there is a lack of documentation of objective improvement. Therefore, continued use of this medication would not be supported. The request as submitted failed to indicate the frequency and the quantity of medication being requested. Given the above, the request for Amrix 15 mg is not medically necessary.

**Naprosyn 500 mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines indicate that NSAIDS are recommended for short term symptomatic relief of low back pain. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual patient treatment goals. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review failed to provide documentation of an objective decrease in pain. The request as submitted failed to indicate the frequency and quantity of medication being requested. Given the above, the request for Naprosyn 500 mg is not medically necessary.