

Case Number:	CM15-0037701		
Date Assigned:	03/06/2015	Date of Injury:	09/17/2001
Decision Date:	04/14/2015	UR Denial Date:	02/26/2015
Priority:	Standard	Application Received:	02/27/2015

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: North Carolina
 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 65-year-old male, who sustained an industrial injury on 9/17/2001. The diagnoses have included lumbar radiculopathy, lumbar post-laminectomy syndrome, lumbar degenerative disc disease and chronic pain syndrome. Treatment to date has included therapy, acupuncture and medication. According to the progress report dated 1/30/2015, the injured worker complained of low back pain and bilateral leg pain. He state that he was experiencing increased pain in the low back. He stated that the current medications were managing the painful symptoms well. Current medications included Norco, Cymbalta and a Lidoderm patch. Physical exam revealed tenderness to palpation of the lumbar paraspinous area and decreased range of motion. Authorization was requested for eight sessions of aquatic therapy. Medications were renewed. On 2/26/2015 Utilization Review (UR) non-certified, a request for Duloxetine 60mg #30 and aquatic therapy times eight for the lumbar spine. UR modified a request for Norco 10/325mg #120 to Norco 10/325mg #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Duloxetine 60 mg Qty 30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duloxetine (Cymbalta) Page(s): 15.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines cymbalta Page(s): 43-44.

Decision rationale: The California chronic pain medical treatment guidelines section on Duloxetine states: Duloxetine (Cymbalta) recommended as an option in first-line treatment option in neuropathic pain. Duloxetine (Cymbalta) is a norepinephrine and serotonin reuptake inhibitor antidepressant (SNRIs). It has FDA approval for treatment of depression, generalized anxiety disorder and for the treatment of pain related to diabetic neuropathy, with effect found to be significant by the end of week 1 effect measured as a 30% reduction in baseline pain). The starting dose is 20-60 mg/day, and no advantage has been found by increasing the dose to twice a day, except in fibromyalgia. The medication has been found to be effective for treating fibromyalgia in women with and without depression, 60 mg once or twice daily. (Arnold, 2005) The most frequent side effects include nausea, dizziness and fatigue. GI symptoms are more common early in treatment. The side effect profile of Duloxetine is thought to be less bothersome to patients than that of tricyclic antidepressants. Note: On October 17, 2005, [REDACTED] and the U.S. Food and Drug Administration (FDA) notified healthcare professionals of revision to the PRECAUTIONS/Hepatotoxicity section of the prescribing information for Cymbalta. Postmarketing reports of hepatic injury (including hepatitis and cholestatic jaundice) suggest that patients with preexisting liver disease who take duloxetine may have an increased risk for further liver damage. The new labeling extends the Precaution against using Cymbalta in patients with substantial alcohol use to include those patients with chronic liver disease. It is recommended that Cymbalta not be administered to patients with hepatic insufficiency. See also Antidepressants for chronic pain for general guidelines, as well as specific Duloxetine listing for more information and references. On June 13, 2008, the FDA approved a new indication for duloxetine HCl delayed-release capsules (Cymbalta; [REDACTED]) for the management of fibromyalgia in adults. The FDA notes that although duloxetine was effective for reducing pain in patients with and without major depressive disorder, the degree of pain relief may have been greater in those with comorbid depression. Treatment of fibromyalgia with duloxetine should be initiated at 30 mg/day for 1 week and then uptitrated to the recommended 60-mg dose. (Waknine, 2008) Note: This drug was recently included in a list of 20 medications identified by the FDA's Adverse Event Reporting System that are under FDA investigation. (FDA, 2008) The requested medication is a first line option in the treatment of neuropathic pain per the California MTUS. Per the progress notes, the patient has persistent and constant neuropathic pain. The patient has no indication of hepatic disease so there would be no major contraindications to the medication. For these reasons, criteria for use of the medication have been met and the request is certified.

Aquatic Therapy, 8 sessions, Lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 22, 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines aquatic therapy Page(s): 22.

Decision rationale: The California chronic pain medical treatment guidelines section on aquatic therapy states: Aquatic therapy recommended as an optional form of exercise therapy, where available, as an alternative to land based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. For recommendations on the number of supervised visits, see Physical medicine. Water exercise improved some components of health-related quality of life, balance, and stair climbing in females with fibromyalgia, but regular exercise and higher intensities may be required to preserve most of these gains. (Tomas-Carus, 2007) There is no indication in the provided documentation that this patient has a condition such as extreme obesity that would preclude the patient from land-based physical therapy. The request for physical therapy is within the recommended number of session but he need for aquatic versus land-based physical therapy has not been established. For these reasons, criteria have not been met for the requested service and it is not certified.

Norco 10/325 mg Qty 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids: On-going Management Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 76-84.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The four A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain dairy that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug

screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to nonopioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse.

When to Continue Opioids; (a) If the patient has returned to work; (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) Chronic back pain: Appears to be efficacious but limited for short-term pain relief, and long term efficacy is unclear (>16 weeks), but also appears limited. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. There is no evidence to recommend one opioid over another. In patients taking opioids for back pain, the prevalence of lifetime substance use disorders has ranged from 36% to 56% (a statistic limited by poor study design). Limited information indicated that up to one-fourth of patients who receive opioids exhibit aberrant medication taking behavior. (Martell-Annals, 2007) (Chou, 2007) The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. The most recent progress reports do not note the patients work status. The patient continues to have significant pain without documented significant improvement in other outcome measures and function. For these reasons, the criteria set forth above of ongoing and continued used of opioids have not been met. Therefore, the request is not certified.