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| <b>Case Number:</b>   | CM14-0146935 |                              |            |
| <b>Date Assigned:</b> | 09/12/2014   | <b>Date of Injury:</b>       | 03/01/2004 |
| <b>Decision Date:</b> | 10/16/2014   | <b>UR Denial Date:</b>       | 08/30/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 09/10/2014 |

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 56-year-old female who reported an injury on 03/01/2004. The mechanism of injury was not submitted for review. The injured worker has diagnoses of spinal/lumbar degenerative disc disease, low back pain, disc disorder of the lumbar spine, cervical pain, depressive disorder, and chronic pain syndrome. Past medical treatment consists of physical therapy, cervical epidural steroid injections, and medication therapy. On 03/10/2014, the injured worker underwent an MRI of the thoracic spine and the neck. On 08/14/2014, the injured worker complained of right shoulder and neck pain. It was noted in the physical examination that the injured worker had a pain rate of 8/10. Inspection of the shoulder revealed no deformity or swelling. Range of motion was restricted with flexion and extension. Examination of the spine revealed paravertebral muscles were tender on both sides. Tenderness was also noted at the manubriosternal joint, paracervical muscles, and mobile somewhat tender soft mass on left neck unchanged measuring 2.5 by 2.5 cm in diameter. The medical treatment plan is for the injured worker to continue the use of medication therapy. The rationale and Request for Authorization form were not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cymbalta 30mg #90 with 2 refills that was provided on 08/14/2014:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Duloxetine (Cymbalta), Page(s): 43.

**Decision rationale:** The request for Cymbalta 30mg #90 with 2 refills that was provided on 08/14/2014 is not medically necessary. The California MTUS Guidelines recommend Cymbalta as an option in first line treatment for neuropathic pain. The assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. There was a lack of evidence of objective assessment of the injured worker's pain level. Furthermore, there was a lack of documented evidence of the efficacy of the injured worker's medications. The frequency of the medication was not provided in the request as submitted. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request is not medically necessary.

**Clonazepam 0.5mg #60 with 2 refills that was provided on 08/14/2014:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24..

**Decision rationale:** The request for Clonazepam 0.5mg #60 with 2 refills that was provided on 08/14/2014 is not medically necessary. California MTUS Guidelines do not recommend the use of benzodiazepines for long term use, because long term efficacy is unproven and there is a risk for dependence. Most guidelines limit use to 4 weeks. The request as submitted is for Clonazepam 0.5mg #60 with 2 refills, totaling a 4 month supply, exceeding the recommended guidelines to limit of 4 weeks. Additionally, the reported documentation did not indicate the efficacy of the medication to support continued use. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request is not medically necessary.

**Unknown prescription of Lido cream that was provided on 08/14/2014:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesia, Lidocaine, Page(s): 111.

**Decision rationale:** The request for Unknown prescription of Lido cream that was provided on 08/14/2014 is not medically necessary. The California MTUS Guidelines state that topical compounds are largely experimental in use with few randomized control trials to determine efficacy or safety and are primarily recommended for neuropathic pain when trials of

antidepressants and anticonvulsants have failed. Additionally, any compounded product that contains at least 1 drug that is not recommended is not recommended. The guidelines state that Lidoderm patch is the only topical form of lidocaine approved. The guidelines do not recommend topical lidocaine in any other form other than Lidoderm. The submitted documentation did not indicate that the injured worker had not responded or was intolerant to other treatments. Additionally, there was no indication in the medical documents that indicated that the injured worker had trialed and failed antidepressants or anticonvulsants. The request as submitted did not indicate a dosage, frequency, or duration of the medication. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request is not medically necessary.