

<b>Case Number:</b>	CM14-0077782		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	05/14/1998
<b>Decision Date:</b>	12/05/2014	<b>UR Denial Date:</b>	05/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/27/2014

### 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 underlying date of injury in this case is 05/14/1998. The date of the initial utilization review under appeal is 05/06/2014. There are no physician notes available at this time applicable to the items under review. An initial utilization review on 05/06/2014 states that the only clinical information available at that time was a physician note of 11/12/2013. That utilization review discusses the available medical records as documenting a history of chronic low back pain radiating to the lower extremities, worse on the right than the left, with a prior history of discectomy and laminectomy at L4-L5. The patient was noted to have decreased sensation in the bilateral L5 and S1 distributions. The initial utilization review noted that there was no discussion regarding the use of Hydrocodone which is a listed medication as of 11/12/2013, and there was no documentation of functional benefits of Cymbalta or Provigil. The reviewer did recommend certification of retrospective use of Colace, given continued use of narcotics as of November 2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective Duloxetine 60mg #50, DOS 11/12/13: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants; Fibromyalgia; Low Back Pain, Chronic.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Duloxetine Page(s): 15.

**Decision rationale:** The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on Duloxetine, page 15, states that this medication is FDA approved for anxiety, depression, diabetic neuropathy, and fibromyalgia and can be used off-label for neuropathic pain and radiculopathy. Given the absence of physician office notes at this time, it is not possible to apply this guideline in support of the efficacy or benefit of Duloxetine. Therefore, this request is not medically necessary.

**Retrospective Hydrocodone 5/325 #90, DOS 11/12/13: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Ongoing Management Page(s): 78.

**Decision rationale:** The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on opioids/ongoing management, discusses the 4 A's of opioid management on page 78, emphasizing the need for documentation of pain relief, functional status, appropriate medication use, and side effects. The medical records are very limited at this time and do not clearly document any indication or functional benefit or overall assessment regarding the efficacy of Hydrocodone. This request is not medically necessary.

**Retrospective Doclance 100mg #60: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids/Initiating Treatment Page(s): 77.

**Decision rationale:** The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on opioids/initiating treatment, page 77, recommends prophylactic treatment of constipation when a patient is being treated with opioids. Available medical records are very limited but do confirm the use of opioid medication as of the date of service of 11/12/2013 under review. Therefore, this medication is supported by the treatment guidelines. This request is medically necessary.

**Retrospective Modafinil 200mg #50, DOS 11/12/13: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Online Version, Pain Chapter, Modafinil

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, modafinil.

**Decision rationale:** This medication is not discussed in the Medical Treatment Utilization Schedule. Official Disability Guidelines/Treatment in Workers Compensation/Pain does discuss this medication, noting that it is not recommended solely to counteract sedation effects of narcotics until after first considering reducing excessive narcotic prescribing. The medical records at this time are extremely limited and do not clearly document a rationale or indication or benefit from Modafinil for this patient. Thus, the guidelines have not been met. This request is not medically necessary.