

Case Number:	CM14-0112423		
Date Assigned:	08/01/2014	Date of Injury:	11/07/2007
Decision Date:	07/09/2015	UR Denial Date:	06/25/2014
Priority:	Standard	Application Received:	07/18/2014

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. 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: New York, Tennessee
 Certification(s)/Specialty: Emergency Medicine

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 42-year-old female, who sustained an industrial injury on 11/07/2007. She reported low back pain from repetitive motion while loading a cargo van. The injured worker was diagnosed as having other pain disorders related to psychological factors, chronic pain syndrome, history of opioid and benzodiazepine dependency, status post inpatient detox, and history of avascular necrosis of both hips. Treatment to date has included diagnostics, chiropractic, acupuncture, physical therapy, multiple injections, spinal cord stimulator implant, mental health treatment, functional restoration program, and medications. On 6/16/2014, the injured worker complained of ongoing back pain. Her mood was appropriate. Current medications included Gralise, Robaxin, Trazadone, Cymbalta, Flexeril, Naprosyn, Buspar, Protonix, and Lidoderm. Medication refills were requested, and also 40hours/week in home caretaking (due to pain and dependency on family) and psychological counseling.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cymbalta 60mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain page(s): 15-16. Decision based on Non-MTUS Citation Drugs for Psychiatric disorders, Treatment Guidelines from The Medical Letter, June 1, 2013 (Issue 130).

Decision rationale: Cymbalta is duloxetine, a selective serotonin and norepinephrine reuptake inhibitors (SNRI). It is FDA-approved for anxiety, depression, diabetic neuropathy, and fibromyalgia. Used off-label for neuropathic pain and radiculopathy. Duloxetine is recommended as a first-line option for diabetic neuropathy. No high quality evidence is reported to support the use of duloxetine for lumbar radiculopathy. More studies are needed to determine the efficacy of duloxetine for other types of neuropathic pain. Side effects include dizziness, fatigue, somnolence drowsiness, anxiety and insomnia. Withdrawal effects can be severe. Abrupt discontinuation should be avoided and tapering is recommended before discontinuation. In this case, the patient is being treated for major depressive disorder with cymbalta 60mg twice daily. The requested dosage of cymbalta surpasses the daily-recommended maximum of 60mg daily. Therefore, the request is not medically necessary.

Trazodone 100mg: 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), Mental Illness and Stress.

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, Insomnia Treatment.

Decision rationale: Trazodone is a tetracyclic antidepressant usually prescribed for insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. Insomnia treatment should be based on etiology. Most medications have only been evaluated for short-term use (less than 4 weeks). 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. Sedating antidepressants are often used to treat insomnia; however, there is less evidence to support their use for insomnia. They may be an option in patients with coexisting depression. Trazodone is one of the most commonly prescribed agents for insomnia. Side effects of this drug include nausea, dry mouth, constipation, drowsiness, and headache. Negative next-day effects such as ease of awakening may offset improvements in sleep onset. Tolerance may develop and rebound insomnia has been found after discontinuation. The patient has been taking this medication since at least July 2014. The duration of treatment surpasses the recommended short-term duration of two to six weeks. Increased duration of treatment increases the risk of tolerance and other adverse effects. Therefore, the request is not medically necessary.

Bupirone 15mg: 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), Pain (Chronic).

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, Anxiety Medications in Chronic Pain.

Decision rationale: Buspirone is a 5-HT_{1A} agonist approved for short-term relief of anxiety symptoms. Efficacy is decreased in patients with recent prior benzodiazepine use. In this case, the patient had been taking the medication since at least March 2014. The duration of treatment requested surpasses short-term duration. Therefore, the request is not medically necessary.

In-Home Care taking (40-hours per week): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services page(s): 51.

Decision rationale: Chronic Pain Medical Treatment Guidelines state that home health services are recommended only for recommended medical treatment in patients who are homebound, on a part-time or intermittent basis, generally up to no more than 35 hours per week. Medical treatment does not include personal care like bathing, dressing, or toileting and it does not include homemaker services like shopping, laundry, or cleaning. In this case there is no documentation that the patient is home bound or requires in home medical treatment. Home health care is not medically indicated. Therefore, the request is not medically necessary.

Medication Management and Psychological Counseling Sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Treatment page(s): 101-102. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Behavioral Interventions.

Decision rationale: Chronic Pain Medical Treatment Guidelines state that psychological treatment is recommended for appropriately identified patients during treatment for chronic pain. The guidelines also state that psychological intervention includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders. There should be an initial trial of 3-4 visits of psychotherapy over 2 weeks to determine if there is functional improvement. With evidence of objective functional improvement, recommended number of visits is a total of up to 6-10 visits over 5-6 weeks.

In this case, there is no documentation of the number of visits requested. The lack of documentation does not allow determination of necessity. Therefore, the request is not medically necessary.