

<b>Case Number:</b>	CM15-0127461		
<b>Date Assigned:</b>	07/14/2015	<b>Date of Injury:</b>	12/29/2009
<b>Decision Date:</b>	08/10/2015	<b>UR Denial Date:</b>	06/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/01/2015

### 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: New Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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 male, who sustained an industrial injury on 12/29/09. He has reported initial complaints of low back pain and injury. The diagnoses have included chronic low back pain status post lumbar fusion and lumbar radiculopathy. Treatment to date has included medications, activity modifications, diagnostics, surgery, physical therapy, transcutaneous electrical nerve stimulation (TENS) and other modalities. Currently, as per the physician progress note dated 6/1/13, the injured worker complains of low back pain that radiates to the lower extremities. He reports increased pain described as being like pins and needles and electric shock and rated 7-10/10 on pain scale. He reports that the pain medications make him more active with his activities of daily living (ADL). The physical exam reveals tenderness to palpation across the low back, there is decreased lumbar range of motion, the sensation is decreased to pinprick bilaterally, he ambulates with a single point cane and straight leg raise is positive bilaterally. The current medications included OxyContin, Norco, Soma, and Cymbalta. The urine drug screen dated 1/13/15 was inconsistent with the medications prescribed. The physician requested treatments included Cymbalta 30mg DR #60, 1 refill and Quazepam 15mg #30.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cymbalta 30mg DR #60, 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 15-16.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Specific Antidepressants Page(s): 15-16.

**Decision rationale:** Cymbalta is FDA approved for diabetic neuropathy. It is also used off label for neuropathic pain and radiculopathy. There is no high quality evidence to support its use for lumbar radiculopathy. There is no clear evidence that the patient have diabetic neuropathy. A prolonged use of cymbalta in this patient cannot be warranted without continuous monitoring of its efficacy. Therefore, the request of 60 Cymbalta 60mg with 1 refill is not medically necessary.

**Quazepam 15mg #30:** Upheld

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

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

**Decision rationale:** According to ODG guidelines and in the treatment of insomnia section. "Recommend that treatment be based on the etiology, with the medications recommended below. See Insomnia. 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. (Lexi-Comp, 2008) Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. The specific component of insomnia should be addressed: (a) Sleep onset; (b) Sleep maintenance; (c) Sleep quality; & (d) Next-day functioning. Pharmacologic Treatment: There are four main categories of pharmacologic treatment: (1) Benzodiazepines; (2) Non-benzodiazepines; (3) Melatonin & melatonin receptor agonists; & (4) Over-the-counter medications. The majority of studies have only evaluated short-term treatment (i.e., 4 weeks) of insomnia; therefore more studies are necessary to evaluate the efficacy and safety of treatments for long-term treatment of insomnia. In 2007, the FDA requested that manufacturers of all sedative-hypnotic drugs strengthen product labeling regarding risks (i.e., severe allergic reactions and complex sleep-related behaviors, such as sleep driving). It is recommended that treatments for insomnia should reduce time to sleep onset, improve sleep maintenance, avoid residual effects and increase next day functioning. (Morin, 2007) (Reeder, 2007) (1) Benzodiazepines: FDA-approved benzodiazepines for sleep maintenance insomnia include estazolam (ProSom), flurazepam (Dalmane), quazepam (Doral), and temazepam (Restoril). Triazolam (Halcion) is FDA-approved for sleep-onset insomnia. These medications are only recommended for short-term use due to risk of tolerance, dependence, and adverse events (daytime drowsiness, anterograde amnesia, next-day sedation, impaired cognition, impaired psychomotor function, and rebound insomnia). These drugs have been associated with sleep-related activities such as sleep driving, cooking and eating food, and making phone calls (all while asleep). Particular concern is

noted for patients at risk for abuse or addiction. Withdrawal occurs with abrupt discontinuation or large decreases in dose. Decrease slowly and monitor for withdrawal symptoms. Benzodiazepines are similar in efficacy to benzodiazepine-receptor agonists; however, the less desirable side-effect profile limits their use as a first-line agent, particularly for long-term use." According to MTUS guidelines, benzodiazepines are not recommended for long-term use for pain management because of unproven long-term efficacy and because of the risk of dependence. Most guidelines limit their use to 4 weeks. There is no recent documentation of insomnia related to pain. The patient was using the medication for long time without clear benefit. Therefore, the prescription of Quazepam 15mg #30 is not medically necessary.