

Case Number:	CM15-0173953		
Date Assigned:	09/15/2015	Date of Injury:	05/10/2005
Decision Date:	10/15/2015	UR Denial Date:	08/04/2015
Priority:	Standard	Application Received:	09/03/2015

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 67 year old male, who sustained an industrial-work injury on 5-10-05. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar strain and sprain, lumbar radiculopathy, lumbar degenerative disc disease (DDD), and post laminectomy pain syndrome. Treatment to date has included pain medication, Cymbalta since at least 7-27-15, psych care, diagnostics, lumbar surgery times 2 last one in 2013, spinal cord stimulator implant 7-14-15, physical therapy (unknown amount) and other modalities. Medical records dated (3-3-15 to 7-27-15) indicate that the injured worker complains of chronic low back pain with 9 year history of low back pain and right leg radicular symptoms with increased complaints in the last 3 months of pain in the left side. He also complains of progression of right leg pain. He also has numbness and tingling down both legs. The pain is rated 9 out of 10 on pain scale without medications and decreases to 7 out of 10 on pain scale with medications. This has been unchanged from previous visits. The injured worker reports that the medications assist him to be able to walk clean around the house drive the car for short distances and self-care while taking breaks. Per the treating physician report dated 2-18-15 the injured worker is permanent and stationary. The physical exam dated from (3-3-15 to 7-27-15) reveals positive straight leg raise on the right at 45-60 degrees in LO5 distribution, positive straight leg raise on the left at 45-60 degrees in L5 distribution, mild to moderate palpable spasms bilateral paraspinal musculature with positive twitch response, decreased lumbar range of motion due to pain and slowed ambulation. The physician indicates that he will be started on Cymbalta to improve chronic musculoskeletal pain and titrate to pain relief. The treating

physician indicates in the medical record dated 7-27-15 that the urine drug test result was consistent with the medication prescribed. The original Utilization review dated 8-4-15 non-certified a request for Cymbalta 30mg #30 as there is not sufficient documentation or rationale for use and non-certified a Urine drug screen, unspecified, but recommended a point of care screen with confirmation of any unexpected request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cymbalta 30mg #30: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Duloxetine (Cymbalta).

Decision rationale: The California MTUS section on Cymbalta states: 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. The patient has documented symptomatic neuropathic pain with no contraindications to the medication. Therefore the request is medically necessary.

Urine drug screen: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states: 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 4 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

non-adherent) 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 diary 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. The California MTUS does recommend urine drug screens as part of the criteria for ongoing use of opioids. The patient was on opioids at the time of request and therefore the request is medically necessary.