

Case Number:	CM15-0176815		
Date Assigned:	09/17/2015	Date of Injury:	02/29/2008
Decision Date:	11/02/2015	UR Denial Date:	08/28/2015
Priority:	Standard	Application Received:	09/08/2015

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 York

Certification(s)/Specialty: Anesthesiology

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 55 year old female, who sustained an industrial-work injury on 2-29-08. She reported initial complaints of low back pain. The injured worker was diagnosed as having lumbar DDD (degenerative disc disease), post-traumatic stress disorder, chronic pain disorder, and bilateral sciatica, pain related insomnia, and pain related depression and anxiety. Treatment to date has included medication, psychologist, and surgery (L4-5 and L5-S1 discectomy and fusion. CT scan reports were reported on 8-2-15 of the thoracic spine revealed status post thoracolumbar fusion with prior T9 vertebroplasty with no hardware failure. Currently, the injured worker complains of chronic low back pain with radicular symptoms to bilateral lower extremities with extension of pain to the upper back, neck, and shoulders. Per the emergency department physician's note on 8-8-15, exam noted normal range of motion, no midline cervical, thoracic or lumbar spine tenderness, neurological exam demonstrated normal strength, normal gait, reflexes were normal and symmetric. The IW weaned off all narcotics, has pain, and had pain. On 8-6-15, the treating physician's exam notes positive impingement sign bilaterally with forward flexion and abduction in bilateral shoulders, cross abduction testing and supraspinatus motor testing are noted. Range of motion measure at cervical spine is moderately decreased in all planes, tenderness to palpation is noted throughout the lumbar spine and bilateral lumbar paraspinal regions, seated straight leg raise is noted to be limited due to pain, and decreased sensation to light touch at bilateral thigh with paresthesia noted in the bilateral lower legs. The Request for Authorization date was 8-25-15 and requested service that included Cymbalta 60mg Qty. 60.00 + 1 refill, Neurontin 300mg Qty. 240 + 1 refill, Ibuprofen 800mg Qty. 90 + 1 refill,

Ativan 1 mg Qty. 120, Trazondone HCL 50mg Qty. 60 + 1 refill. The Utilization Review on 8-28-15 denied the request since documentation for Cymbalta and Trazadone submitted lack evidence of efficacy, use of Neurontin does not demonstrate functional benefit, use of Ibuprofen does not demonstrate functional benefit, and Ativan, long term use is not recommended and not medically necessary, per CA MTUS (California Medical Treatment Utilization Schedule) Chronic pain medical treatment guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cymbalta 60mg Qty. 60.00 + 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): SNRIs (serotonin noradrenaline reuptake inhibitors). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cymbalta, Antidepressants for chronic pain.

Decision rationale: According to the California MTUS Guidelines, antidepressants are indicated for the treatment of chronic musculoskeletal pain. They are recommended as a first-line option for neuropathic pain, and as a possibility for non-neuropathic pain. Cymbalta (Duloxetine) is a norepinephrine and serotonin reuptake inhibitor antidepressant (SNRI). 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 (effect measured as a 30% reduction in baseline pain). In this case, there is no documentation of objective functional benefit with prior medication use. The medical necessity for Cymbalta has not been established. The requested medication is not medically necessary.

Neurontin 300mg Qty. 240 + 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Gabapentin (Neurontin).

Decision rationale: According to the CA MTUS (2009) and ODG, Neurontin (Gabapentin) is an anti-epilepsy drug, which has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia, and has been considered as a first-line treatment for neuropathic pain. The records documented that this patient has neuropathic pain related to her chronic low back condition. Neurontin has been part of her medical regimen. However, there is no documentation of subjective or objective findings consistent with current neuropathic pain to necessitate use of Neurontin. Medical necessity for Neurontin has not been established. The requested medication is not medically necessary.

Ibuprofen 800mg Qty. 90 + 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs.

Decision rationale: Motrin (Ibuprofen) is a non-steroidal anti-inflammatory drug (NSAID). Oral NSAIDs are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. The ODG states that NSAIDs are recommended for acute pain, osteoarthritis, and acute exacerbations of chronic pain. There is no evidence of long-term effectiveness for pain or function. There is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain. Guidelines recommended that the lowest effective dose be used for the shortest duration of time consistent with treatment goals. In this case, the patient has been on previous long-term NSAIDs without any documentation of significant improvement. Medical necessity of the requested medication, Motrin 800mg, has not been established. The request for this medication is not medically necessary.

Activan 1 mg Qty. 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Benzodiazepines.

Decision rationale: According to the CA MTUS guidelines, benzodiazepines are prescribed for anxiety. They are not recommended for long-term use for the treatment of chronic pain because long-term efficacy is unproven and there is a risk of dependency. Ativan (Lorazepam) is a long-acting benzodiazepine, having anxiolytic, sedative, muscle relaxant, anticonvulsant, and hypnotic properties. Most guidelines recommend the use of Ativan for the treatment of anxiety disorders, and as an adjunct treatment for anxiety associated with major depression. However, use of this medication is limited to four weeks. There are no guideline criteria that support the long-term use of benzodiazepines. In addition, the documentation provided did not include the indications or directions for use of the Lorazepam. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

Trazodone HCL 50mg Qty. 60 + 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress Chapter, Trazadone, Insomnia Treatment.

Decision rationale: Trazodone (Desyrel) is recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. It is unrelated to tricyclic or tetracyclic antidepressants and has some action as an anxiolytic. In this case, there is no documentation of a history of depression, anxiety or insomnia. Medical necessity of the requested medication has not been established. The requested medication is not medically necessary.