

<b>Case Number:</b>	CM15-0072544		
<b>Date Assigned:</b>	04/22/2015	<b>Date of Injury:</b>	06/17/2011
<b>Decision Date:</b>	05/20/2015	<b>UR Denial Date:</b>	04/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/15/2015

### 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: California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 58 year old female, who sustained an industrial injury on June 17, 2011. She has reported back pain, shoulder pain, knee pain, and depression. Diagnoses have included right biceps tear, right shoulder impingement syndrome, lumbar spine degenerative disc disease, right knee sprain, myofascial pain of the lumbar spine, and lumbar radiculopathy. Treatment to date has included medications, home exercise, spinal cord stimulator, lumbar spine fusion and removal of hardware, and imaging studies. A progress note dated March 13, 2015 indicates a chief complaint of lower back pain radiating to the left leg, right shoulder pain, and insomnia. The treating physician documented a plan of care that included intrathecal pump trial, and medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Fentanyl 75mcg/hr patch #30 with 1 refill:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (Fentanyl Transdermal System) Section Opioids Section Weaning of Medications Section Page(s): 44, 74-95, 124.

**Decision rationale:** The MTUS Guidelines do not recommend the use of Duragesic patch as a first-line therapy. Duragesic is the trade name of a fentanyl transdermal therapeutic system, which releases fentanyl, a potent opioid, slowly through the skin. The FDA-approved product labeling states that Duragesic is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. They do provide guidance on the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use of opioids may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. The medical documents do document a decrease in pain from 10/10 to 6-8/10 but there is no documented objective functional improvement as a result of chronic opioid treatment. Aberrant behavior has not been assessed as recommended by the MTUS Guidelines when utilizing opioid pain medications. It is not recommended to discontinue opioid treatment abruptly, as weaning of medications is necessary to avoid withdrawal symptoms when opioids have been used chronically. This request however is not for a weaning treatment, but to maintain treatment. The request for Fentanyl 75 mcg/hr patch #30 with 1 refill is not medically necessary.

**Hydrocodone 10/325 #60 with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-going management.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Section Weaning of Medications Section Page(s): 74-95, 124.

**Decision rationale:** The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. The injured worker has had a mild decrease in pain but there is no objective documentation of increased function since beginning the use of hydrocodone. It is not recommended to discontinue opioid treatment abruptly, as weaning of medications is necessary to avoid withdrawal symptoms when opioids have been used chronically. This request however is not for a weaning treatment, but to continue treatment. The request for hydrocodone 10/325 #60 with 1 refill is not medically necessary.

**Cymbalta 60mg #30 with 1 refill:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain Section Page(s): 13-16.

**Decision rationale:** The MTUS Guidelines recommended the use of antidepressants as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Side effects should be assessed, including excessive sedation (especially that which would affect work performance). SSRIs have not been shown to be effective for low back pain (there was not a significant difference between SSRIs and placebo) and SNRIs have not been evaluated for this condition. Additionally, there are no specific medications that have been proven in high quality studies to be efficacious for treatment of lumbosacral radiculopathy. MTUS recommends the use of Duloxetine (Cymbalta) for the treatment of major depressive disorder and the management of pain associated with diabetic peripheral neuropathy. Duloxetine (Cymbalta), an inhibitor of serotonin and norepinephrine reuptake, has been approved for the treatment of major depressive disorder. Duloxetine has been shown to be effective in the treatment of first and subsequent episodes of major depressive disorder, and regardless of duration of the current depressive episode. The medical records for this patient document previous prescriptions for Cymbalta but no functional benefit including sleep quality/duration and psychological assessment. The request for Cymbalta 60mg #30 with 1 refill is not medically necessary.