

Case Number:	CM15-0026886		
Date Assigned:	02/18/2015	Date of Injury:	01/10/2009
Decision Date:	04/07/2015	UR Denial Date:	01/17/2015
Priority:	Standard	Application Received:	02/11/2015

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: Physical Medicine & Rehabilitation

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 46 year old woman sustained an industrial injury on 1/10/2009 after falling backward at work. Current diagnoses include status post permanent spinal cord stimulator implant, bilateral upper extremity chronic regional pain syndrome/reflex sympathetic dystrophy, right shoulder tendonitis, left shoulder tendonitis with impingement, left shoulder capsulitis, status post left elbow ulnar nerve surgery, and left shoulder internal derangement. Treatment has included oral medications. Physician notes dated 1/5/2015 show complaints of bilateral upper extremity pain that has worsened and now includes weakness. Recommendations include home healthcare, Abilify, Cymbalta, Klonopin, Norco, random urine toxicology testing, and follow up in four weeks. On 1/17/2015, Utilization Review evaluated a prescription for Klonopin 2mg 100 tablets, that was submitted on 1/27/2015. The UR physician noted that this medication is not recommended for long term use and may worsen anxiety over time. The MTUS, ACOEM Guidelines, (or ODG) was cited. The request was modified and subsequently appealed to Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Klonopin 2mg tablet #45 with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13, 24, 51, 74-97.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines chapter 'Pain chronic' and topic 'Benzodiazepine'.

Decision rationale: The patient presents with unrated and worsening bilateral upper extremity pain, worse on the left with numbness and parasthesias to the left upper extremity. The patient's date of injury is 01/10/09. Patient is status post spinal cord stimulator implant placement on 06/23/11, left ulnar nerve transposition on 12/18/09. The request is for KLONOPIN 2MG TABLET #45 WITH 5 REFILLS. The RFA was not provided. Physical examination dated 01/05/15 of the left upper extremity reveals tenderness upon palpation, hypersensitivity, discoloration of the skin with a mottled color in the left hand. Treater notes restricted range of motion secondary to pain, positive forearm provocative maneuver to the left upper extremity. The patient is currently prescribed Klonopin, Zofran, Abilify, Lidoderm, Cymbalta, and Hydrocodone. Diagnostic imaging was not included. The patient is not currently working. ODG guidelines, chapter 'Pain chronic' and topic 'Benzodiazepine', have the following regarding insomnia treatments: "Not recommended for long-term use (longer than two weeks), because long-term efficacy is unproven and there is a risk of psychological and physical dependence or frank addiction. Most guidelines limit use to 4 weeks." The MTUS Guidelines page 24 states, "benzodiazepines are not recommended for long-term use because long-term efficacies are unproven and there is a risk of dependence." In this case, a prescription for Klonopin was first noted in progress report dated 09/08/14, and the patient has been using the medication consistently at least since then. In progress report dated 01/05/15, treater does not document efficacy of this medication. ODG guidelines recommend Klonopin for insomnia and the patient has not been diagnosed with the condition. In fact, none of the reports document any sleep complaints. Additionally, the patient has been using the medication for 4 months with no documented efficacy. Both MTUS and ODG guidelines do not support the long-term use of Klonopin, the requested 45 tablets with 5 refills does not imply short duration use. Therefore, the request IS NOT medically necessary.

18 Home healthcare 3 days per week for 6 months: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13, 24, 51, 74-97.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines home service Page(s): 51.

Decision rationale: The patient presents with unrated and worsening bilateral upper extremity pain, worse on the left with numbness and parasthesias to the left upper extremity. The patient's date of injury is 01/10/09. Patient is status post spinal cord stimulator implant placement on 06/23/11, left ulnar nerve transposition on 12/18/09. The request is for 18 HOME HEALTHCARE 3 DAYS PER WEEK FOR 6 MONTHS. The RFA was not provided. Physical examination dated 01/05/15 of the left upper extremity reveals tenderness upon palpation,

hypersensitivity, discoloration of the skin with a mottled color in the left hand. Treater notes restricted range of motion secondary to pain, positive forearm provocative maneuver to the left upper extremity. The patient is currently prescribed Klonopin, Zofran, Abilify, Lidoderm, Cymbalta, and Hydrocodone. Diagnostic imaging was not included. The patient is not currently working. MTUS Guidelines page 51 has the following regarding home service, "recommended only for otherwise recommended medical treatment for 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 homemaker services like shopping, cleaning, laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed." There are no discussions provided regarding this request, it is unclear exactly what the home health care aide is required for. MTUS Guidelines recommend generally up to no more than 35 hours per week; the treater is also not clear on how many hours per visit this patient will require, only 3 times a week for 6 months. In addition, there is no documentation of paralysis, significant neurologic deficits, or functional loss to prevent this patient from self-care and performing the necessary ADLs. The patient does have complex regional pain syndrome of the left upper extremity, it may be difficult but not unreasonable to do self-care and carry out ADLs on her own. MTUS does not support home care assistance, if ADL assistance is the only service required. Therefore, the request IS NOT medically necessary.

Cymbalta 60mg #60 with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13,24, 51, 74-97.

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

Decision rationale: The patient presents with unrated and worsening bilateral upper extremity pain, worse on the left with numbness and paresthesias to the left upper extremity. The patient's date of injury is 01/10/09. Patient is status post spinal cord stimulator implant placement on 06/23/11, left ulnar nerve transposition on 12/18/09. The request is for CYMBALTA 60 #60 WITH 5 REFILLS. The RFA was not provided. Physical examination dated 01/05/15 of the left upper extremity reveals tenderness upon palpation, hypersensitivity, discoloration of the skin with a mottled color in the left hand. Treater notes restricted range of motion secondary to pain, positive forearm provocative maneuver to the left upper extremity. The patient is currently prescribed Klonopin, Zofran, Abilify, Lidoderm, Cymbalta, and Hydrocodone. Diagnostic imaging was not included. The patient is not currently working. MTUS Chronic Pain Medical Treatment Guidelines, pg 13-16 for Antidepressants for chronic pain states: Recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. For Cymbalta specifically, MTUS states it is FDA-approved for anxiety, depression, diabetic neuropathy, and fibromyalgia. Used off-label for neuropathic pain and radiculopathy. In regards to the request for Cymbalta, the treater has not provided adequate documentation of efficacy to continue use. Records provided indicate that this patient has been taking Cymbalta since at least 05/28/14. Most recent progress note dated 02/27/15 does not provide any discussion of efficacy or functional improvement. Cymbalta is recommended for neuropathic pain, and given this patient's complex pathology it is an appropriate therapy. However, without documented pain/functional

improvement attributed to this medication, continued use cannot be substantiated. The request IS NOT medically necessary.

Abilify 2mg #30 with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13, 24, 51, 74-97.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Mental Illness & Stress Chapter, Aripiprazole Abilify.

Decision rationale: The patient presents with unrated and worsening bilateral upper extremity pain, worse on the left with numbness and paresthesias to the left upper extremity. The patient's date of injury is 01/10/09. Patient is status post spinal cord stimulator implant placement on 06/23/11, left ulnar nerve transposition on 12/18/09. The request is for ABILIFY 2MG #30 WITH 5 REFILLS. The RFA was not provided. Physical examination dated 01/05/15 of the left upper extremity reveals tenderness upon palpation, hypersensitivity, discoloration of the skin with a mottled color in the left hand. Treater notes restricted range of motion secondary to pain, positive forearm provocative maneuver to the left upper extremity. The patient is currently prescribed Klonopin, Zofran, Abilify, Lidoderm, Cymbalta, and Hydrocodone. Diagnostic imaging was not included. The patient is not currently working. ODG-TWC, Mental Illness & Stress Chapter, Aripiprazole, Abilify Section states: "Not recommended as a first-line treatment. Abilify, aripiprazole is an antipsychotic medication. Antipsychotics are the first-line psychiatric treatment for schizophrenia. There is insufficient evidence to recommend atypical antipsychotics for conditions covered in ODG." In regards to the request for a continuation of Abilify for the management of this patient's chronic pain, treater has not provided a reason for the request or documented prior efficacy. Abilify has been prescribed since at least 05/28/14, though treater does not document efficacy in the subsequent reports. Additionally, the treater has not discussed specific reason for utilizing this medication. Guidelines do not recommend Abilify as first-line treatment, as it has insufficient support for conditions covered by ODG. Therefore, the request IS NOT medically necessary.