

Case Number:	CM14-0203330		
Date Assigned:	01/07/2015	Date of Injury:	09/12/1997
Decision Date:	10/20/2015	UR Denial Date:	11/25/2014
Priority:	Standard	Application Received:	12/04/2014

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 70 year old female who sustained an industrial injury on 09-12-1997. According to a progress report dated 11-10-2014, the injured worker was seen for a follow up of chronic pain management, chronic upper back pain, chronic neck pain with right arm radicular pain and chronic left leg pain. She had sustained an injury to her right wrist and was diagnosed with RSD-CRPS right upper extremity. She underwent a series of stellate ganglion block with "improvement". Pain returned. She was evaluated by several specialists and the diagnosis of RSD-CRPS right upper extremity was confirmed. Various medications included neuropathic and narcotic medications. She underwent a trial of spinal cord stimulator, which was positive. She then underwent implantation of a permanent spinal cord stimulator device, which had to be repositioned. The spinal cord stimulator provided 30% relief and decreased the frequency of stellate ganglion blocks. She later underwent replacement of the generator and exploration for the leads. She developed a significant amount of infection. The generator was removed from the left buttocks. Her back pain increased. Her principal treatment has included stellate ganglion blocks every 2-4 months, trigger point injections and narcotic pain medications. The injured worker had lost 60 pounds. Fentanyl patch use had been decreased from 100 mcg to 50 mcg every 8 hours. Currently symptoms were stable. The injured worker requested re-evaluation for a spinal cord stimulator implantation. Current medication use was stable, adequate and providing "good" pain relief. This medication was "increasing functionality and quality of life". Worse pain was rated 10 on a scale of 1-10. Least pain was 8-9. Usual pain was rated 9. The provider noted that pain was worse, sleep pattern was worse and functionality was worse. Medication

usage was decreased. Current medications included Duragesic patch 75 mcg-hour every 48 hours, topical analgesic cream, Cymbalta 60mg once a day, Oxybutynin, Welchol, Glimepiride, Oseni, Crestor and Armour thyroid. Allergies included Cipro (upset stomach) and OxyContin (bowel problems). Physical examination demonstrated diminished range of motion of the neck. Examination of the extremities demonstrated diminished muscle mass and muscle tone and right grip and C5 motor weaker than left. Examination of the spine demonstrated scars from previous surgeries, positive straight leg raise bilaterally and restricted and painful spine extension. Gait favored the left lower extremity. Generalized "hypotonia" was noted. Piriformis tenderness was present on the left. Greater trochanter area tenderness was present on the left. Decreased pin sensation C8, C7, C5 noted. Coordination was significantly impaired. Gait was antalgic. Diagnoses included chronic pain syndrome, complex regional pain syndrome type I of the upper limb, sprain of muscle, acute pain due to trauma, pain in joint shoulder region, obesity and nonindustrial diabetes mellitus, unspecified hyperlipidemia and unspecified hypothyroidism. The provider noted that the injured worker had benefited from use of Duragesic 75 mcg, that an opiate risk assessment had been carried out and that a narcotic agreement was in place. Patch counts, urine toxicology screens were carried out regularly and CURES reports were reviewed. The injured worker was permanent and stationary. The treatment plan included spinal cord stimulator implantation, Duragesic patch 75 mcg #15 refills 1 and Cymbalta 60 mg #30 refills 1. Documentation shows long-term use of Fentanyl patch and Cymbalta. An authorization request dated 11-10-2014 was submitted for review. The requested services included Fentanyl patch 75 mcg per hour #15, Cymbalta 60 mg #30 and consult for spinal cord stimulator revision. On 11-25-2014, Utilization Review modified the request for Fentanyl patch 75 mcg #15 and Cymbalta 60 mg #30. The request for 1 consult for spinal cord stimulator revision was conditionally non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fentanyl patch 75mcg #15: 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): Opioids for chronic pain, Opioids, dosing, Opioids, long-term assessment.

Decision rationale: The claimant has a remote history of a work injury occurring in September 1997 and continues to be treated for chronic pain including a diagnosis of right upper extremity CRPS. Treatments have included stellate ganglion blocks and a spinal cord stimulator that, when replaced after six years had to be removed due to infection. When seen, her symptoms were stable. Pain was rated at 8-10/10. Physical examination findings included a BMI of over 35. There was decreased grip strength. Straight leg raising was positive bilaterally. Spinal range of motion was decreased and painful. There was left trochanteric tenderness. There was an antalgic gait with impairment of coordination. Medications were continued including Duragesic at 75 mcg per hour and Cymbalta 60 mg daily. Guidelines recommend against opioid dosing is in excess of 120 mg oral morphine equivalents per day. In this case, the total MED being prescribed

is 1.5 times that recommended. There are no unique features of this case that would support dosing at this level and there is no documentation that this medication is providing decreased pain, an increased level of function, or improved quality of life. Weaning of the currently prescribed medications is not being actively done. Ongoing prescribing at this dose is not medically necessary.

Cymbalta 60mg #30: 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): Duloxetine (Cymbalta). Decision based on Non-MTUS Citation Cymbalta prescribing information.

Decision rationale: The claimant has a remote history of a work injury occurring in September 1997 and continues to be treated for chronic pain including a diagnosis of right upper extremity CRPS. Treatments have included stellate ganglion blocks and a spinal cord stimulator that, when replaced after six years had to be removed due to infection. When seen, her symptoms were stable. Pain was rated at 8-10/10. Physical examination findings included a BMI of over 35. There was decreased grip strength. Straight leg raising was positive bilaterally. Spinal range of motion was decreased and painful. There was left trochanteric tenderness. There was an antalgic gait with impairment of coordination. Medications were continued including Duragesic at 75 mcg per hour and Cymbalta 60 mg daily. The claimant has neuropathic pain and has undergone numerous treatments, which appear to have been ineffective. In terms of Cymbalta (duloxetine), it can be recommended as an option in first-line treatment of neuropathic pain. The maximum dose is 120 mg per day. In this case, it appears ineffective at the current dose and titration is not being planned. Ongoing prescribing at this dose is not medically necessary.