

Case Number:	CM13-0014190		
Date Assigned:	01/03/2014	Date of Injury:	08/16/2011
Decision Date:	03/24/2014	UR Denial Date:	07/31/2013
Priority:	Standard	Application Received:	08/20/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 45-year-old male with date of injury on 08/16/2011. The progress report dated 07/01/2013 by [REDACTED] indicates that the patient's diagnoses include: (1) S/P fluoroscopically-guided permanent spinal cord stimulator implant, (2) Complex regional pain syndrome, bilateral upper extremity, (3) Bilateral elbow pain, (4) Bilateral wrist pain, (5) S/P bilateral cubital tunnel release, (6) S/P carpal tunnel release, (7) Bilateral upper extremity repetitive injury, (8) Bilateral ulnar neuropathy/neuritis, (9) Bilateral median neuropathy, neuritis, (10) Asthma, (11) Kidney stone, (12) Psoriasis. The patient continues with bilateral upper extremity pain and neck pain radiating to the trapezius on the right. Exam findings include bilateral hand, wrist, skin hyperalgesia, allodynia, mild edema, hypoesthesia, atrophic skin changes including temperature and skin color change. Bilateral shoulder range of motion was restricted by pain in all directions. A request was made for the patient to continue on medications. Utilization review letter dated 07/31/2013 had issued non-certification of oxycodone 10/325 mg 1 tablet every 4 hours, and Lidocaine patches one to the back over the spinal cord stimulator implant site.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 10/325mg, one (1) tablet every four (4) hours: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56-57, 79-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-81.

Decision rationale: The patient continues with significant bilateral upper extremity pain as well as neck pain radiating to the right trapezius muscle area. MTUS Guidelines page 88 and 89 regarding long term use of opioids recommends that pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument. Page 78 MTUS has the following regarding ongoing management of opioid medication: Ongoing review and documentation 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 last. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function or improved quality of life. I reviewed 7 progress reports dated between 01/31/2013 and 07/01/2013. These reports did not provide documentation of pain relief, functional status, appropriate medication use, and side effects from the opioid medication. Therefore, recommendation is for denial.

Lidocaine patches, one (1) to the back over the spinal cord stimulator (SCS) implant site:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56-57.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Page(s): 111-113.

Decision rationale: The patient continues with significant pain in the bilateral upper extremities and neck pain radiating to the right trapezius area. MTUS Guidelines page 111 through 113 regarding topical analgesics under the section for topical lidocaine indicates that it is recommended for neuropathic pain that is localized after there has been evidence of a trial of first line therapy such as tricyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica. The records appear to indicate the patient has had complaints of neuropathic pain and has been on previous medication including gabapentin and Lyrica. The records appear to indicate that the lidocaine patches were requested to be placed over the spinal cord stimulator implant site. The request for Lidoderm patches in this case appear to be reasonable and supported by the guidelines noted above, therefore, authorization is recommended.