

Case Number:	CM14-0104767		
Date Assigned:	07/30/2014	Date of Injury:	09/25/2003
Decision Date:	09/19/2014	UR Denial Date:	06/12/2014
Priority:	Standard	Application Received:	07/07/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in New York and Texas. 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/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 injured worker is a 47 year old male injured on 09/25/03 due to an undisclosed mechanism of injury. Diagnoses include chronic pain syndrome and complex regional pain syndrome (CRPS) of the right upper extremity. The clinical note dated 04/02/14 indicated the injured worker presented complaining of bilateral hand pain with worsening right hand pain described as constant and burning. The injured worker reported left hand pain that comes and goes. The injured worker reported any movement and use of hands worsens pain and pain medication decreases pain. Pain level with the use of medication is rated at 2/10 and 7/10 without the use of medication. The injured worker reported denial of Hydromorphone resulted in an increased pain level over the previous month. The injured worker reported the use of medication provides 50% pain relief. Objective findings include severely decreased range of motion with shoulder abduction/flexion/extension, severe allodynia palmar portion right 3rd, 4th, and thumb, severely decreased right hand grip strength, severely decreased range of motion in the right wrist flexion/extension/lateral bending due to pain, and decreased grip strength of the right hand. Prior treatment included physical therapy, NSAIDs, opiates, stellate ganglion blocks, spinal cord stimulator placement and removal. The documentation indicated the injured worker was opiate dependent and experiencing hyperalgesia due to opiates and weaning was recommended per complex AME. The clinical note indicated intent to continue Morphine ER 80mg to improve pain and function and wean Dilaudid by 1 tablet every 4 weeks as tolerated. Treatment plan included consideration of Suboxone therapy to help wean narcotics. The request for Dilaudid 4mg #60 was initially non-certified on 06/12/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Dilaudid 4 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear indication that attempts to wean the injured worker are being made. Further, the request failed to provide the frequency and number of refills to be provided. As such, the medical necessity of Dilaudid 4 mg #60 cannot be established at this time.