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| Case Number: | CM14-0012851 | | |
| Date Assigned: | 02/24/2014 | Date of Injury: | 03/03/2000 |
| Decision Date: | 08/07/2014 | UR Denial Date: | 01/08/2014 |
| Priority: | Standard | Application Received: | 01/31/2014 |

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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:

This is a 56-year-old female patient with a 3/3/2000 date of injury. She injured herself due to cumulative trauma. A 12/18/13 progress report indicated that the patient continued to have bilateral upper extremity pain, 8/10, more in the right side. She reported that her pain aggravated with dressing up, showering, and household chores. The patient stated that medication helped her with pain management. She was diagnosed with Carpal tunnel syndrome and Elbow/forearm sprain. Treatment to date: medication management, Carpal tunnel release surgery on 9/18/12, functional restoration program, and home exercise program. There was documentation of agitation due to Tramadol. There was a note in regards to unspecified adverse side effects from Etodolac. There is documentation of a previous 1/8/14 adverse determination. In regards to Buprenorphine, there was no indication that the patient was opiate-addicted or was in a detoxification program. Diclofenac sodium cream was not certified, because there was no documentation supporting insufficiency of oral NSAIDs.

IMR ISSUES, DECISIONS AND RATIONALES

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

BUPRENORPHINE 0.1MG SUBLINGUAL TROCHES #30PC QTY. 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines BUPRENORPHINE FOR CHRONIC PAIN.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA (Buprenorphine).

Decision rationale: CA MTUS does not address this issue. ODG states that buprenorphine is recommended as an option for treatment of chronic pain (consensus based) in selected patients (not first-line for all patients). Suggested populations: (1) Patients with a hyperalgesic component to pain; (2) Patients with centrally mediated pain; (3) Patients with neuropathic pain; (4) Patients at high-risk of non-adherence with standard opioid maintenance; (5) For analgesia in patients who have previously been detoxified from other high-dose opioids. Use for pain with formulations other than Butrans is off-label. Due to complexity of induction and treatment the drug should be reserved for use by clinicians with experience. The patient presented with bilateral upper extremity pain, 8/10. The provider indicated that the patient started to use Buprenorphine, because of Tramadol/APAP induced agitation. However, there was documentation that the patient was taking this medication since July of 2013 and there was no evidence of objective pain relief. There was no documentation of lack of adverse side effects, CURES monitoring, or urine drug screens. Therefore the request for Buprenorphine 0.1mg sublingual troches #30pc qty. 60 was not medically necessary.

DICLOFENAC SODIUM 1.5% 60 GRAM QTY. 1 (DOS 11.20.13): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines DICLOFENAC (VOLTAREN).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

Decision rationale: CA MTUS states that Voltaren Gel is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist); and has not been evaluated for treatment of the spine, hip or shoulder. The patient presented with bilateral upper extremity pain, 8/10. The provider indicated that the patient had side effects due to Etodolac. However, it is unclear where the patient will be using the gel. In addition, guidelines support a 1% formulation, and this request is for a 1.5% formulation. There is no specific rationale provided as to why this medication is necessary despite lack of guidelines support. Therefore, the request for Diclofenac Sodium 1.5%, 60gm qty. 1 (DOS: 11.20.13): was not medically necessary.