

Case Number:	CM14-0175641		
Date Assigned:	10/28/2014	Date of Injury:	07/09/2010
Decision Date:	12/05/2014	UR Denial Date:	10/06/2014
Priority:	Standard	Application Received:	10/23/2014

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 & Pain Management, has a subspecialty in Pain Medicine and is licensed to practice in Oklahoma 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 55-year-old male who reported an injury on 07/09/2010. The mechanism of injury was not submitted for clinical review. The diagnoses included bilateral carpal tunnel syndrome status post bilateral carpal tunnel syndrome, status post bilateral carpal tunnel release, left Carpal Tunnel Release (CTR) on 09/30/2010, right carpal tunnel release on 11/11/2010, residual carpal tunnel syndrome postop, bilateral non-dermatomal regional neuropathic hand pain, complex chronic pain syndrome, depression secondary to chronic pain, motor and sensory distal peripheral neuropathy, status post total knee arthroscopy on 10/02/2013. The medication regimen included methadone, oxycodone, Lyrica, Cymbalta, Terazosin, Simvastatin, and Amlodipine. The previous treatments included medication and surgery. Within the clinical note dated 09/12/2014 it was reported the injured worker complained of neuropathic pain in the upper extremity. He described the pain as burning, hot and electrical pain with numbness and tingling. He rates his pain 3/10 in severity with medication, and 8/10 in severity without medication. The injured worker reported functional improvement in pain with the current medication regimen. The most recent urine drug screen dated 09/12/2014 was consistent with the current prescribed medication. Upon the physical examination, the provider noted the injured worker had 1+ swelling in the distal upper extremity. There was slight hyperpathia noted. The provider requested oxycodone for moderate to severe breakthrough pain, and methadone for baseline pain relief. The request for authorization was not submitted for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 10mg #150: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 77-78.

Decision rationale: The request for oxycodone 10 mg #150 is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. The clinical documentation submitted indicated the injured worker to have decreased pain with medication regimen. A urine drug screen was submitted for clinical review. The clinical documentation provided indicated the injured worker had functional improvement with the medication. However, the request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

Methdone HCL 10mg #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 77-78.

Decision rationale: The request for methadone HCl 10 mg #180 is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. The clinical documentation submitted indicated the injured worker to have decreased pain with medication regimen. A urine drug screen was submitted for clinical review. The clinical documentation provided indicated the injured worker had functional improvement with the medication. However, the request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.