

Case Number:	CM14-0023267		
Date Assigned:	05/14/2014	Date of Injury:	06/19/2009
Decision Date:	07/10/2014	UR Denial Date:	02/11/2014
Priority:	Standard	Application Received:	02/24/2014

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 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 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 patient is a 65 year-old female who was injured on 6/19/2009. She has been diagnosed with history of fall with fracture of right 4th metacarpal; history of ORIF right wrist in 2010 with residuals; history of left shoulder rotator cuff tear s/p arthroscopy, 7/28/10; s/p left distal radial and ulnar fracture; s/p left tibia/fibula fracture with ORIF; history of depression; history of opioid dependence with previous drug rehab. According to the 1/31/14 anesthesiology/pain management report from [REDACTED], the patient had an increase in right upper extremity pain in the hand and elbow, without any injury or trauma. She has been using morphine ER 30mg in the morning, that lasts 8-9 hours and using Percocet 10/325mg for breakthrough pain. She reports 7/10 pain with medications, and 10/10 without. [REDACTED] recommends titrating MSER 30mg up to bid, and continue Percocet 10/325mg 1-2 tablets q4-6 hours prn, #210, max 7/day; and also requests a trial Lidoderm patch. On 2/11/14 UR denied the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

MORPHINE SULFATE ER 30MG, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids- On Going Management Page(s): 78-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria For Use Of Opioids Page(s): 76-80.

Decision rationale: MTUS guidelines on a therapeutic trial of opioids states "If partial analgesia is not obtained, opioids should be discontinued." In this case, there was no improvement in pain levels compared to baseline with the addition of MSER 30mg. The request for continued or increased MSER when partial analgesia was not obtained is not in accordance with MTUS guidelines. Therefore, the request for Morphine Sulfate ER 30 mg # 60 is not medically necessary and appropriate.

PERCOCET 10/325MG, #210: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids- on Going Management Page(s): 80-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Long Term Opioid Usage Page(s): 76-80.

Decision rationale: MTUS states a satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. In this case, there is no change in the pain assessment with addition or removal of medications. Between 11/4/13 and 12/2/13, the patient reports increasing pain levels for no apparent reason. The Percocet dosage remained the same at 7/day during the increased symptoms. The patient reports increased pain levels, and there is no improvement in function and no mention of improved quality of life with use of Percocet. The request to continue with a medication that is not providing a satisfactory response is not in accordance with MTUS guidelines. Therefore, the request for Percocet 10/325 mg # 120 is not medically necessary and appropriate.

LIDODERM PATCH 5%, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine Patch) Page(s): 56.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm; Topical Analgesics Page(s): 56-57, 111-113.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines states topical lidocaine can be used for neuropathic pain after evidence of first line therapy. In this case, there is no indication the patient has neuropathic pain, and no mention of any first-line therapy such as tri-cyclic or SNRI antidepressants or AED such as Gabapentin or Lyrica. The request for Lidoderm Patch % # 60 is not medically necessary and appropriate.